

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

PRINTED 01/11/2016
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/18/2015
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERDALE APARTMENTS ROAD PINEVILLE, KY 40977
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<p>F 000 INITIAL COMMENTS</p> <p>F 250 SS=G 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p>	<p>An abbreviated survey (KY24135) was initiated on 12/15/15 and concluded on 12/18/15. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "G" level.</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility Social Service Worker (SSW) job description, it was determined the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of five (5) sampled residents (Residents #3 and #5). Resident #3 was involved in a resident-to-resident incident resulting in Resident #3 being slapped in the face by Resident #5 on 12/13/15. Although the SSW initially investigated, there was no documented evidence of further Social Services follow-up assessments and documentation with interventions related to this resident's mood, fear, or depression after the 12/13/15 incident. Interview with Resident #3 revealed the resident was "afraid" of Resident #5 and would not come out of his/her room anymore due to the fear of being hit by Resident #5. In addition, although the SSW was aware of Resident #5 being</p>	<p>Mountain View Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Mountain View Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>Resident # 3 and # 5 are no longer in the facility.</p> <p>On December 18, 2016 the Assistant Director of Nurses (ADON) conducted a head to toe assessment of Resident #1 and Resident A. Assessment findings revealed no indication of injury to either Resident # 1 or to Resident A.</p> <p>Resident # 5 wheeled herself and her "baby" doll around both units of the facility, therefore all in house residents had the potential to be affected.</p> <p>On December 18, 2016 the Social Service Director (SSD), Director of Nurses (DON), ADON, Staff Development Coordinator (SDC) or Quality Assurance (QA) Nurse conducted an interview with residents who had a BIMS score of 8 or more and conducted a head to toe assessment of those resident's with a BIMS score of 99 or 7 and below. The purpose of this process was to assess each resident's potential for fear of harm from other residents, visitors and/or staff and to assess for the potential signs/indication of harm</p>	<p>F 250 01/03/16</p> <p>F 250 01/24/2016</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Wuran Lambert Adm. 01/24/2016

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 250	<p>Continued From page 1</p> <p>combative and striking other residents in the past, there was no documented evidence of the incidents in the social services notes with interventions related to the incidents.</p> <p>The findings include:</p> <p>Review of the job description for the SSW revealed the SSW was responsible for planning, developing, organizing, implementing, evaluating, and directing the Social Services Department in accordance with federal, state, and local standards as well as established policies and procedures to ensure that the medically related emotional and social needs of the patients/residents were met and maintained on an individual basis. Further review revealed the SSW would work with emotional problems including assisting residents/family with anxiety and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death and the need for institutional and specialized care, maintain written documentation in the medical record per facility policy and state and federal guidelines, and develop the social service component of the resident's plan of care identifying specific problems, goals, and approaches.</p> <p>Review of incident reports revealed on 09/01/15 Resident #5 was combative and trying to get into the bed of an unsampled resident (Resident A). Further review of the incident report revealed a witness statement entered by Licensed Practical Nurse (LPN) #3 that stated Resident #5 was smacking the arm of Resident A in Resident A's room on 09/01/15 at 7:45 PM. The documentation further revealed that Resident #5</p>	F 250	<p>to those residents who could not communicate those fears/harm to the staff.</p> <p>On December 18, 2015 there were 51 resident's interviewed by the SSD, DON, ADON, SDC or the QA Nurse. Six (6) of the 51 residents interviewed voiced concerns/grievances. The concerns of those six (6) residents were addressed promptly by SDC, QA Nurse, DON, ADON, or SSD.</p> <ol style="list-style-type: none"> 1. Resident # 3 Informed the QA nurse of the happenings on December 13, 2015 between Resident # 3 and resident # 5. QA Nurse reassured resident # 3 that resident # 5 was no longer in the facility. 2. Resident B informed the QA nurse that there was a "fear" of Resident # 5 due to Resident # 5 "shaking hand, as if going to strike out, perhaps bother B's "stuff" and that Resident # 5 cursed a lot. B denied that Resident # 5 had ever touched, cursed or bothered B's "stuff". B also stated that there was a fear of Resident # 10. B stated that another resident holds his/her hand, like a friend and that Resident # 10 does not like that. Resident B denied any interactions between the two of them. Resident B further stated that some of the staff are loud and curse at night, however B could not identify any specific staff members. The QA Nurse immediately reassured resident that the friendship between B and other resident was okay, if both residents welcomed it. The QA nurse validated that there had never been any altercation between B and residents # 	

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F 250	Continued From page 2 was put on 15-minute checks on 09/02/15 from 7:00 AM to 6:45 AM on 09/03/15. Review of another incident report dated 11/24/15 revealed Resident #5 slapped Resident #1 on 11/24/15. The incident report stated that Resident #5 was re-educated "on how physical violence is not appropriate and to ask staff for assistance with getting through hallway." Review of another incident report dated 12/13/15 revealed Resident #5 slapped Resident #3 on 12/13/15. The incident report stated that Resident #5 was removed from the hallway and taken to his/her room and 15-minute checks were initiated and continued until 12/16/15 at 9:45 PM. The incident report further revealed the physician ordered an additional dose of Xanax (medication used to treat anxiety) on 12/13/15. 1. Review of Resident #5's medical record revealed that the resident was admitted on 08/27/15 with diagnoses that included Altered Mental Status, Atherosclerotic Heart Disease, Hypertension, Anxiety Disorder, Conductive Hearing Loss, Hemiplegia and Hemiparesis, Cerebrovascular Disease Affecting, Hypothyroidism, and Type II Diabetes. Review of the Physician Discharge Summary Outline dated 08/27/15 from the resident's previous hospitalization revealed the resident was hospitalized due to agitation, aggressive behaviors, striking at staff, and verbally threatening staff and peers. Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated 12/03/15 revealed that the resident's Cognitive Skills for Daily Decision Making were assessed at a score of 2 that indicated the resident was moderately impaired (decisions poor, cues/supervision required). Review of the comprehensive care plan dated	F 250	10, and/or # 5. An on the spot in-service was provided to staff, by SSD and SDC, related to noise level and cursing while on duty and in resident care areas being unacceptable. 3. Facility roster, identifies that Resident # 11 reported to the QA Nurse that upon returning from smoke break one day that he/she made attempts to go around Resident # 12. At that time Resident # 12 ran walker into resident # 11's wheel chair (W/C), trying to keep Resident # 11 from passing Resident # 12. Resident # 11 reported he told Resident # 12 to "let me get by you", in a nice manner. Resident # 11 stated "they did go down the hall together and there were no more issues between them". 4. Facility roster identifies Resident # 13 voiced a concern related to his/her roommate pushing an over bed table toward him/her and that it was pushed aside by resident # 13. Resident # 13 stated, "I had not reported this to anyone", SSD instructed Resident # 13 to immediately notify staff if anything like this occurred in the future. SSD also asked Resident # 13 if a room change would be desired, resident # 13 responded "yes". The SSD assessed the available rooms and the one most suitable for resident # 13. Resident # 13 toured the available rooms and	

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F 250	Continued From page 3 08/27/15 revealed the resident wandered and was at risk for unsupervised exits from the facility related to cognitive impairment and the inability to locate the resident's own room. The interventions to address the problems were assigned to the social worker and were to allow the resident to ventilate feelings regarding nursing home placement. Further review of the care plan revealed "non-pharmacological interventions" were as follows: allow/encourage the resident to make choices, approach the wandering resident in a non-threatening manner, be careful to not invade the resident's personal space, break activities into manageable subtasks, give one instruction at a time, encourage loved ones to visit, encourage small group activities, and give the resident an item or task in an attempt to distract (the resident has a baby doll and believes it to be real). Review of the Social Progress Notes signed by the SSW dated 09/16/15 revealed the resident "will swing/hit at staff/others" and was "easily annoyed/agitated at times." Review of the Cognitive Pattern for the last seven days dated 12/03/15 revealed the resident was confused and propelled self via a wheelchair throughout the facility with cues and redirection required; required assistance from staff to the dining room for meals because the resident did not know the location or time meals were served; and the resident was unable to recall three words out of three after five minutes. Interview with the Social Service Worker on 12/18/15 at 10:30 AM revealed that the Director of Nursing (DON) informed the SSW to interview residents after a resident-to-resident incident occurred. The SSW stated she was unaware of the incidents involving Resident #5 and other residents that occurred on 09/01/15 and 11/24/15	F 250	chose the one that was desired. Resident # 13 was relocated to alternate room of his choice on December 21, 2015. 5. Facility roster identifies resident # 14, who voiced a concern that "felt like the staff might hurt me, if they got mad enough because I get up at night and because I can't sleep." When asked by the SSD, Resident # 14 further that "no" staff had never said or done anything "to me". Resident # 14 stated, "I hear them [the staff] talking about me every night". Resident # 14 has diagnosis of bipolar disorder, paranoid schizophrenia, depression with psychotic features. 6. Facility roster identified resident # 15 as reporting "afraid of another resident, because they had threatened to bust" resident # 15 "in the face" the day before in the dining room, during resident council meeting. This could not have occurred at that time due to residents being on opposite ends of the dining room and the SSD was present. On December 18, 2015 the DON, ADON, SDC or QA Nurse completed a head to toe assessment on 35 in house residents, who could not be interviewed. Assessments revealed there was no indications of harm to any of those 35 residents.		

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F 250	<p>Continued From page 4 and therefore did not provide other social services.</p> <p>2. Review of Resident #3's medical record revealed the facility admitted the resident on 04/25/09 with diagnoses that included Difficulty in walking, Cerebrovascular Disease, Muscle wasting and atrophy, Major Depressive Disorder, and Anxiety Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/08/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 12 indicating the resident was moderately cognitively impaired and was interviewable.</p> <p>Review of Resident #3's comprehensive care plan revealed a problem dated 10/12/15 of alteration in mood, Depressive Disorder and Anxiety, with trouble falling asleep. The goal for the problems was to have improved mood state with no signs or symptoms of anxiety/depression through the next review, and to have improved sleep pattern as evidenced by reporting adequate rest with no insomnia through next review. The interventions included: administer medications per Physician's Orders, update for any changes in mood, continue psychiatric evaluation as indicated, encourage social activities and verbalization of feelings, and encourage loved ones to keep in contact/visit or go on family outings. There was no documented evidence the care plan was revised to indicate increased anxiety, fear, or depression related to the incident that occurred with Resident #5 on 12/13/15.</p> <p>Review of the nurse's notes from Resident #3's record dated 12/13/15 at 4:44 PM revealed Resident #5 was yelling in the hallway and then a</p>	F 250	<p>The SSD was educated by the Administrator related to medically related social service needs of the residents. Administrator copied and presented the regulations from the long term care survey manual to the SSD. Part of that education included a new tool titled "SSD Communication Tool". The tool is to begin with other employees of the nursing home and forwarded to the SSD for investigation and interview of the identified medically related social service needs of the individual resident. The SSD will follow up on each identified medically related social service issue with the appropriate departments such as DON, Minimum Data Set (MDS) nurse, maintenance, and/or therapy as indicated by the referral. SSD completed a competency exam related to medically related social service needs on December 29, 2016.</p> <p>On December 23, 2016 the SSD and Administrator reviewed the SSD job description. The SSD's duties will change as it relates to resident's podiatry, dental, vision, hearing services and appointments. The staffing coordinator will pick the following duties up, effective February 1, 2016 as it relates to scheduling of appointments, follow-ups, and will keep the SSD informed of the services. The staffing coordinator will be educated by the administrator prior to February 1, 2016 of new expectations.</p> <p>The regulation F 250 was reviewed, by the administrator in the December 23, 2015 QA Committee meeting. Between December 29, 2016 and January 3, 2016 all facility employees were educated on medically related social service needs, the communication tool and each of our responsibilities to ensure that all our</p>	<p>F250 Cont</p>

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F 250	<p>Continued From page 5</p> <p>"slap" noise was heard. The note further revealed when staff arrived, Resident #5 was holding Resident #3's wheelchair with one hand, and slapping Resident #3 with the other hand. Resident #5 slapped Resident #3 on the left cheek. The note stated that Resident #3 was assessed and had no redness to the cheek at that time. The note stated that Resident #3 was upset about the incident and Resident #5 was removed from the room.</p> <p>Review of the nurse's notes revealed follow-up charting on 12/14/15 and 12/15/15 with no further concerns noted. Review of the nurse's note on 12/15/15 at 3:15 PM revealed that Resident #3 has been kept separated from the resident with whom the altercation occurred.</p> <p>There was no documented evidence of Social Services interventions related to the incident on 12/13/15.</p> <p>Interview with Resident #3 on 12/15/15 at 9:30 AM revealed that he/she was sitting in the hall waiting on staff to put him/her in bed on 12/13/15 when "out of nowhere" Resident #5 got behind Resident #3's wheelchair and pushed it into the wall almost causing him/her to fall out of the wheelchair. Resident #3 stated that Resident #5 then came around to the side of Resident #3's wheelchair and smacked him/her across the face on the left side. Resident #3 stated he/she would not let Resident #5 do that again because he/she was going to stay in the room and not come out anymore; Resident #3 stated "I am afraid" of him/her and nurse aides have bruises from Resident #5 and "I am afraid to sit in the hallway; I enjoyed sitting in the hallway but I am not going out there because of" Resident #5.</p>	F 250	<p>residents medically related social service needs were met. A competency exam was completed by each participant. There were 5 staff members who did not complete the education or competency exams on those dates related to being off. Two (2) staff completed the required education and exam on January 5, 2016 and two (2) completed them on January 7, 2016. One (1) remains on suspension with undetermined date of return.</p> <p>A "QA resident interview" tool, was developed to interview residents and identify any issues/concerns the residents have. The tool includes overall treatment of residents by staff, staff courtesy and respect of residents, if the residents feel they are being treated in a dignified manner by staff, feelings of safety in the facility, misuse of the resident's property, fear of staff, other residents or visitors, dining experience, food quality, and the residents ADL care.</p> <p>All staff involved in the QA meeting will have an assignment to participate in the QA resident interview process for identifying resident concerns and fear of others. Residents with a BIMs score of 8-15 will be interviewed quarterly by a member of the QA team. Some of the items: feelings of safety, misuse of resident property, fear of staff, other residents or visitors will require immediate intervention by interviewee and notification of the facility Administrator; other questions: overall treatment of residents by staff, if the residents feel they are being treated in a respectful, courteous and dignified manner by staff, dining experience, quality of food, and ADL Care will require a prompt response by interviewee and appropriate department head. However, any</p>		

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F 250	Continued From page 6	F 250	issue may be brought to the administrator's attention immediately if the interviewee has any concerns about the nature of the findings of the QA resident interviews. The QA interviews will be reported five days a week by each QA member as audits are conducted. Each QA member will report cumulative totals of resident interviews and answers to the Executive QA Committee Quarterly. The QA committee will provide further guidance and instructions as needed based on report findings.		
F 280 SS=G	<p>Interview with the Social Service Worker on 12/18/15 at 10:30 AM revealed she interviewed Resident #3 on 12/14/15 and asked what happened. The SSW reported that Resident #3 said he/she was sitting in the wheelchair outside his/her room and Resident #5 pushed Resident #3's wheelchair and slapped Resident #3. The SSW stated she investigated the incident between Resident #3 and Resident #5, but did not ask Resident #3 if the resident was afraid, or how the incident made the resident feel.</p> <p>Interview with the DON on 12/16/15 at 5:39 PM and 12/18/15 at 12:55 PM revealed she was not aware that Resident #5 had been involved in three altercations with other residents since 09/01/15. She stated when an incident occurred the nurse on the floor started the investigation, and then the SSW, DON, and Administrator completed the investigation if it was "really bad."</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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, and, to the extent practicable, the participation of</p>	F 280	<p>Residents who have a BIMS score of 99 or 7 and below will have a head to toe skin audit completed quarterly by the DON, ADON, SDC or QA Nurse. Based on assessment findings the assessor will take immediate and/or prompt actions to address any identified concerns. DON, ADON, SDC, or QA nurse will report findings to QA committee five (5) days per week and will report cumulative findings quarterly to the Executive QA Committee for further instructions.</p> <p>A total of 20 residents per month will either be interviewed or have a head to toe skin assessment by QA Committee members ongoing with reports to the QA Committee five (5) days per week and to the Executive QA Committee quarterly. The QA Committee will change process as it deems appropriate based on findings of interviews/head to toe assessments.</p> <p>Further actions, such as physician and family notification, completion of concern/grievance forms, investigation and notification of the appropriate state agencies and law enforcement agencies will be based upon assessment/interview findings.</p>		

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F 280	<p>Continued From page 8</p> <p>revealed the resident was "afraid" of Resident #5 and would not come out of his/her room anymore due to the fear of being hit by Resident #5.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan policy, dated October 2007, revealed the Interdisciplinary Care Plan Team developed care plans within seven days after completion of the Comprehensive Minimum Data Set assessment. The policy further stated that the care plans were updated quarterly, annually, upon significant change in a resident's condition, or as indicated.</p> <p>1. Review of Resident #5's medical record revealed the facility admitted the resident on 08/27/15 with diagnoses that included Altered Mental Status, Atherosclerotic Heart Disease, Hypertension, Anxiety Disorder, Conductive Hearing Loss, Hemiplegia and Hemiparesis, Cerebrovascular Disease, Hypothyroidism, and Type II Diabetes. Review of the Physician Discharge Summary Outline from the resident's previous hospitalization dated 08/27/15 revealed the resident was hospitalized due to agitation, aggressive behaviors, striking at staff, and verbally threatening staff and peers. Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated 12/03/15 revealed that the resident's cognitive skills for daily decision making were assessed at a score of 2 which indicated that the resident was moderately impaired (decisions poor, cues/supervision required). Review of the comprehensive care plan dated 08/27/15 revealed the resident wandered and was at risk for unsupervised exits from the facility related to cognitive impairment and the inability to locate the resident's own</p>	F 280	<p>appropriate department for assessment and revision of the resident's care plan as necessary.</p> <p>Between December 29, 2015 and January 03, 2016 the administrator provided general education to all staff which included: noticing and reporting changes they see in residents in order for licensed nurses to follow up with assessment, physician/family notification and revision of the residents' plan of care based on those changes and assessment findings.</p> <p>After the 100% review of all in house BOPs by the SSD related to behaviors and care plan revisions by licensed nurses and the SSD, SSD will print and review all in-house resident BOPs weekly for the previous 7 day period and will make care plan revisions as needed based on each resident's weekly BOP review. The QA Committee members, as indicated by topic, will review the 24 hour nursing report, physician orders, and conduct five (5) day a week progress notes to ensure notification and care plan revisions occur timely.</p> <p>The DON, ADON, QA nurse will audit a total of 12 care plans per month to ensure the resident's care plans are being reviewed and revised as indicated by the 24 hour reports, order changes and progress notes five (5) days per week. The Minimum Data Set (MDS) Nurse, DON, ADON and/or QA Nurse will report identified problems to the QA Committee five (5) days per week and will report to the executive QA meeting quarterly. This process will continue for six (6) months then as directed by the QA Committee.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2015
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977		
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F 280	Continued From page 9 room. The interventions to address the problems were assigned to the social worker and were to allow the resident to ventilate feelings regarding nursing home placement. Further review of the care plan revealed "non-pharmacological interventions" were as follows: allow/encourage the resident to make choices, approach the wandering resident in a non-threatening manner, be careful to not invade the resident's personal space, break activities into manageable subtasks, give one instruction at a time, encourage loved ones to visit, encourage small group activities, and give the resident an item or task in an attempt to distract (the resident has a baby doll and believes it to be real). Review of incident reports revealed on 09/01/15 Resident #5 was being combative and trying to get into the bed of an unsampled resident (Resident A). Further review of the incident report revealed a witness statement entered by Licensed Practical Nurse (LPN) #3 that stated Resident #5 was smacking the arm of Resident A on 09/01/15 at 7:45 PM. The documentation further revealed that Resident #5 was put on 15-minute checks on 09/02/15 from 7:00 AM to 6:45 AM on 09/03/15. Review of another incident report dated 11/24/15 revealed Resident #5 slapped Resident #1 on 11/24/15. The incident report stated that Resident #5 was re-educated "on how physical violence is not appropriate and to ask staff for assistance with getting through hallway." Review of another incident report dated 12/13/15 revealed Resident #5 slapped Resident #3 on 12/13/15. The incident report stated that Resident #5 was removed from the hallway and taken to his/her room and 15-minute checks were initiated and continued until 12/16/15 at 9:45 PM. The incident report further revealed the physician	F 280			

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F 280	<p>Continued From page 10</p> <p>ordered an additional dose of Xanax (medication used to treat anxiety) on 12/13/15.</p> <p>Review of the resident's care plan revealed there was no documented evidence the facility reviewed or revised the care plan after the 09/01/15 and 11/24/15 altercations to prevent further incidents.</p> <p>2. Review of Resident #3's medical record revealed the facility admitted the resident on 04/25/09 with diagnoses that included difficulty in walking, Cerebrovascular Disease, Muscle wasting and atrophy, Major Depressive Disorder, and Anxiety Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/08/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 12 indicating the resident was moderately cognitively impaired and was interviewable.</p> <p>Review of Resident #3's comprehensive care plan revealed a problem dated 10/12/15 of alteration in mood, Depressive Disorder and Anxiety, with trouble falling asleep. The goal for the problems was to have improved mood state with no signs or symptoms of anxiety/depression through the next review, and to have improved sleep pattern as evidenced by reporting adequate rest with no insomnia through next review. The interventions included: administer medications per Physician's Orders, update for any changes in mood, continue psychiatric evaluation as indicated, encourage social activities and verbalization of feelings, and encourage loved ones to keep in contact/visit or go on family outings.</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>Review of the nurse's notes from Resident #3's record dated 12/13/15 at 4:44 PM revealed Resident #5 was yelling in the hallway and then a "stap" noise was heard. The note further revealed when staff arrived, Resident #5 was holding Resident #3's wheelchair with one hand, and slapping Resident #3 with the other hand. Resident #5 slapped Resident #3 on the left cheek. The note stated that Resident #3 was assessed and had no redness to the cheek at that time. The note stated that Resident #3 was upset about the incident and Resident #5 was removed from the room.</p> <p>Review of the nurse's notes revealed follow-up charting on 12/14/15 and 12/15/15 with no further concerns noted. Review of the nurse's note on 12/15/15-at 3:15-PM revealed that Resident #3 has been kept separated from the resident with whom the altercation occurred.</p> <p>Review of the resident's care plan revealed there was no documented evidence the facility reviewed or revised the care plan after the 12/13/15 incident.</p> <p>Interview with Resident #3 on 12/15/15 at 9:30 AM revealed that he/she was sitting in the hall waiting on staff to put him/her in bed on 12/13/15 when "out of nowhere" Resident #5 got behind Resident #3's wheelchair and pushed it into the wall almost causing him/her to fall out of the wheelchair. Resident #3 stated that Resident #5 then came around to the side of Resident #3's wheelchair and smacked him/her across the face on the left side. Resident #3 stated he/she would not let Resident #5 do that again because he/she was going to stay in the room and not come out anymore. Resident #3 stated "I am afraid" of</p>	F 280		

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F 280	<p>Continued From page 12</p> <p>him/her and nurse aides have bruises from Resident #5 and "I am afraid to sit in the hallway; I enjoyed sitting in the hallway but I am not going out there because of" Resident #5.</p> <p>Interview with the Social Service Worker on 12/18/15 at 10:30 AM revealed she interviewed Resident #3 on 12/14/15 and asked what happened. The SSW reported that Resident #3 said he/she was sitting in the wheelchair outside his/her room and Resident #5 pushed Resident #3's wheelchair and slapped Resident #3. The SSW stated she investigated the incident between Resident #3 and Resident #5, but did not ask Resident #3 if the resident was afraid, or how the incident made the resident feel and therefore did not revise the care plan to address Resident #3's fear of Resident #5. Further interview with the SSW revealed that she was unaware of the incidents involving Resident #5 and other residents that occurred on 09/01/15 and 11/24/15 and therefore did not provide other social services or revise the care plan to address the behaviors.</p> <p>Interview with the DON on 12/16/15 at 5:39 PM and 12/18/15 at 12:55 PM revealed she was not aware that Resident #5 had been involved in three altercations with other residents since 09/01/15. She stated when an incident occurred the nurse on the floor started the investigation and then the SSW, DON, and Administrator completed the investigation if it was "really bad." The DON went on to say she would expect the care plan to be updated within two days and it should have been revised after the 09/01/15 incident and the 11/24/15 incident.</p> <p>Interview with the Facility Administrator on</p>	F 280		

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F 280	Continued From page 13 12/18/15 at 1:40 PM revealed she had been employed at the facility for seven days. According to the Administrator, the QA person was responsible for monitoring incident reports and then the administrator was notified and reviewed them also. The Administrator said the only incident involving Resident #5 that she had reviewed was the one dated 12/13/15. The Administrator stated resident care plans should have been updated and appropriate interventions developed after the incidents occurred involving Resident #5.	F 280			
F 312 SS=D	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.	F 312	F 312 Resident # 4's nails were observed on December 18, 2015 by scheduling clerk/SRNA. Nails were clean and had been trimmed/filed and Resident # 4 stated "my nails are fine"	F 312 01/03/16	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure necessary services to maintain grooming and personal hygiene were provided for one (1) of five (5) sampled residents (Resident #4). Observations on 12/15/15 revealed Resident #4 had long nails that were in need of trimming. The findings include: Review of the facility policy titled "Grooming," undated, revealed nail care would be provided daily and as needed.		On December 18, 2015 100% audit of all resident finger was conducted by scheduling clerk/SRNA. 15 residents were identified as needing fingernail care and one (1) resident was identified as needing finger and toe nail care. One resident had long nails and refused to have them done by anyone in the facility but the "activity" SRNA. Nail care was provided to those 16 residents by licensed nurses and/or SRNA's on date identified. On December 23, 2015 the administrator educated the QA Committee related to F 312, from the long term care survey manual. The education included a resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. All departments were educated by the administrator between December 29, 2015 and	F 312 Cont	

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F 312	Continued From page 14 Review of Resident #4's medical record revealed the facility admitted the resident on 11/26/13 with diagnoses that included Atherosclerotic Heart Disease, Epigastric Pain, Diverticulosis, and Hypertension. Review of an annual Minimum Data Set (MDS) assessment dated 11/04/15 revealed Resident #4 required the extensive assistance of one person for personal hygiene. Review of the Brief Interview for Mental Status (BIMS) assessment revealed a score of 15 indicating the resident was interviewable. Review of Resident #4's plan of care dated 11/12/13 revealed that State Registered Nurse Aides (SRNAs) would ensure hair was washed and nails were manicured on bathing days. Observation of Resident #4 on 12/15/15 at 12:05 PM with SRNA #7 revealed the resident's fingernails were long and in need of trimming. Interview with Resident #4 on 12/15/15 at 12:05 PM revealed that Resident #4 liked his/her nails short. The resident said his/her nails were so long now that they were digging into the palm of his/her hand and that staff had not cut them "in a while." Resident #4 stated he/she was not able to cut them because his/her arthritis was too bad. Interview conducted with SRNA #7 on 12/15/15 at 2:08 PM revealed the shower team was responsible for providing the nail care to Resident #4 on his/her bath day. SRNA #7 further stated that Resident #4's last bath/shower was on 12/13/15. The SRNA stated the shower team was required to check and trim a resident's nails on bath days unless they were diabetic and then the nurse was required to trim the resident's nails. SRNA #7 stated that she did not notice that	F 312	January 3, 2016. The education included: when going about daily routines, they should pay attention to each resident's personal appearance. Are they clean? Neat? Nails clean/neatly trimmed? Teeth/dentures clean? Hair combed? Residents can be observed by any employee when walking up/down halls, cleaning rooms, serving meal trays, interacting with resident's in hallways, shaking their hands, etc. Any staff can report to any nursing staff that the resident needs attention to personal care. Educated that nurses do diabetic nail care, nails ideally are cleaned and trimmed on full bath days, as well as other "when needed". A bi-monthly nail audit will be conducted by the scheduling clerk/SRNA. Unless the resident is diabetic the scheduling clerk/SRNA will trim/file resident nails as needed and will report possible referrals needed to podiatry services. The scheduling clerk/SRNA will complete a QA Audit and turn into the QA Committee monthly, and a cumulative report will be turned into the executive QA Committee quarterly by the scheduling clerk/SRNA. The audit and reporting will continue for six (6) months and then as determined by the QA Committee.		

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F 323	Continued From page 16 Review of the facility's "Abuse, Neglect, or Misappropriation of Resident Property Policy" revised 07/01/13, revealed the facility will deploy staff to meet the resident's needs, as appropriate. The facility's staff will investigate allegations in a timely manner and develop corrective measures as indicated. The facility staff will monitor the provision of resident care and services every shift. Further review of the policy revealed a section titled "Resident-to-Resident Aggression." The policy stated that residents who exhibit aggressive physical and verbal behavior may present a risk to the facility's other residents. These behaviors may not be "abuse" since these residents are often not able to willfully intend to harm others, yet they might have the potential to cause injury. The policy stated residents were assessed upon admission for evidence of a pattern of aggressive behavior through the comprehensive assessment process and when a significant risk was identified, the care plan team should develop goals and intervention strategies that address the prevention of injury to other residents and include these items on the resident's care plan. The policy further stated that residents who developed behaviors that present a risk to others after admission were reviewed to determine if a significant change occurred, reassessed if necessary, and referred to the care plan team for revision of the care plan to address the potential for injury to other residents. Residents who present a risk factor to others, whether physical or mental, should be monitored by staff. If the planned interventions were not effective, the care plan should be revised to offer alternative interventions. The policy stated that the Social Worker ensured that the facility works to protect residents from other	F 323	from other residents, visitors and/or staff and to assess for the potential signs/indication of harm to those residents who could not communicate those fears/harm to the staff. On December 18, 2015 there were 51 resident's interviewed by the SSD, DON, ADON, SDC or the QA Nurse. Six (6) of the 51 residents interviewed voiced concerns/grievances. The concerns of those six (6) residents were addressed promptly by SDC, QA Nurse, DON, ADON, or SSD. 1. Resident # 3 informed the QA nurse of the happenings on December 13, 2015 between Resident # 3 and resident # 5. QA Nurse reassured resident # 3 that resident # 5 was no longer in the facility. 2. Resident B informed the QAO nurse that there was a "fear" of Resident # 5 due to Resident # 5 "shaking hand, as if going to strike out, perhaps bother B's "stuff" and that Resident # 5 cursed a lot. B denied that Resident # 5 had ever touched, cursed or bothered B's "stuff". B also stated that there was a fear of Resident # 10. B stated that another resident holds his/her hand, like a friend and that Resident # 10 does not like that. Resident B denied any interactions between the two of them. Resident B further stated that some of the staff are loud and curse at night, however B could not identify any specific staff members. The QA Nurse immediately reassured resident that the friendship between B and other resident was okay, if both residents welcomed it. The QA nurse validated that there had never been any		

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F 323	<p>Continued From page 17 residents through monitoring, assessment, care planning, and referral services.</p> <p>Review of Resident #5's medical record revealed that the resident was admitted on 08/27/15 with diagnoses that included Altered Mental Status, Atherosclerotic Heart Disease, Hypertension, Anxiety Disorder, Conductive Hearing Loss, Hemiplegia and Hemiparesis, Cerebrovascular Disease, Hypothyroidism, and Type II Diabetes. Review of the Physician Discharge Summary Outline from the resident's previous hospitalization dated 08/27/15 revealed the resident was hospitalized due to agitation, aggressive behaviors, striking at staff, and verbally threatening staff and peers. Review of Resident #5's Quarterly Minimum Data Set (MDS) assessment dated 12/03/15 revealed that the resident's Cognitive Skills for Daily Decision Making were assessed as a score of 2 which indicated that the resident was severely impaired. Review of section E0200 (Behavioral Symptoms) from the 12/03/15 MDS revealed the resident was coded as not having any behaviors exhibited in the previous seven days. Review of the care plan dated 08/27/15 revealed the resident displayed wandering behaviors and was at risk for unsupervised exits from the facility. The plan included interventions related to behaviors for staff to ensure alarmed exits were functional; ensure the resident's picture and name were on the wandering board; approach the wandering resident in a non-threatening manner; and allow the resident to ventilate feelings regarding nursing home placement. Review of the care plan dated 12/14/15 revealed that Resident #5 had a history of being easily agitated, anxious, and verbally aggressive/combatative without provocation. The plan included interventions for</p>	F 323	<p>altercation between B and residents # 10, and/or # 5. An on the spot in-service was provided to staff, by SSD and SDC, related to noise level and cursing while on duty and in resident care areas being unacceptable.</p> <p>3. Facility roster, identifies that Resident # 11 reported to the QA Nurse that upon returning from smoke break one day that he/she made attempts to go around Resident # 12. At that time Resident # 12 ran walker into resident # 11's wheel chair (W/C), trying to keep Resident # 11 from passing Resident # 12. Resident # 11 reported he told Resident # 12 to "let me get by you", in a nice manner. Resident # 11 stated "they did go down the hall together and there were no more issues between them".</p> <p>4. Facility roster identifies Resident # 13 voiced a concern related to his/her roommate pushing an over bed table toward him/her and that it was pushed aside by resident # 13. Resident # 13 stated "I had not reported this to anyone", SSD instructed Resident # 13 to immediately notify staff if anything like this occurred in the future. SSD also asked Resident # 13 if a room change would be desired, resident # 13 responded "yes". The SSD assessed the available rooms and the one most suitable for resident # 13. Resident #</p>	<p>F323 Cont</p>

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F 323	<p>Continued From page 18</p> <p>staff to not invade personal space, elicit family input for best approaches to the resident, give medication as prescribed, document episodes of any changes in mood and/or mental status and notify the physician, give resident item or task in an attempt to distract, and document behavior as it occurs (combative/threatening) per facility protocol.</p> <p>Review of incident reports and nurse's notes revealed on 09/01/15 Resident #5 was combative and trying to get into the bed of unsampled Resident A. Further review of the incident report revealed a witness statement entered by Licensed Practical Nurse (LPN) #3 that stated Resident #5 was smacking the arm of Resident A in Resident A's room on 09/01/15 at 7:45 PM. The documentation further revealed that Resident #5 was put on 15-minute checks on 09/02/15 from 7:00 AM to 6:45 AM on 09/03/15. Review of another incident report dated 11/24/15 revealed Resident #5 slapped Resident #1 on 11/24/15. The incident report stated that Resident #5 was re-educated "on how physical violence is not appropriate and to ask staff for assistance with getting through hallway." Review of another incident report dated 12/13/15 revealed Resident #5 slapped Resident #3 on 12/13/15. The incident report stated that Resident #5 was removed from the hallway and taken to his/her room and 15-minute checks were initiated and continued until 12/16/15 at 9:45 PM. The incident report further revealed the physician ordered one additional dose of Xanax (medication used to treat anxiety) on 12/13/15.</p> <p>Observation on 12/17/15 at 6:25 PM revealed Resident #5 was observed to enter Resident #1's room and pass within arm's reach of Resident #1</p>	F 323	<p>chose the one that was desired. Resident # 13 was relocated to alternate room of his choice on December 21, 2015.</p> <p>5. Facility roster identifies resident # 14, who voiced a concern that "felt like the staff might hurt me, if they got mad enough because I get up at night and because I can't sleep." When asked by the SSD, Resident # 14 further that "no" staff had never said or done anything "to me". Resident # 14 stated, "I hear them [the staff] talking about me every night". Resident # 14 has diagnosis of bipolar disorder, paranoid schizophrenia, depression with psychotic features.</p> <p>6. Facility roster identified resident # 15 as reporting "afraid of another resident, because they had threatened to bust" resident # 15 "in the face" the day before in the dining room, during resident council meeting. This could not have occurred at that time due to residents being on opposite ends of the dining room and the SSD was present.</p> <p>On December 18, 2015 the DON, ADON, SDC or QA Nurse completed a head to toe assessment on 35 in house residents, who could not be interviewed. Assessments revealed there was no indications of harm to any of those 35 residents.</p>	

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F 323	Continued From page 19 while four staff members were standing approximately 20 feet away at the nurses' station and could see Resident #1's room. Staff did not intervene when Resident #5 entered Resident #1's room after raising a Velcro door barrier so he/she could roll the wheelchair under it. Resident #5 then rolled his/her wheelchair to the foot of the bed. Resident #5 shouted at Resident A, who was lying in bed closest to the window of the room. Resident A then shouted at Resident #5 to "get out." Facility staff walked by the door at this time and had a clear line of sight of Resident #5 but did not intervene. Resident #5 then rolled the wheelchair back and was by Resident #1's bedside table. Resident #5 was going through Resident #1's drawers, pulling sheets and a pillow off of the bed. Four facility staff members were observed to walk past Resident #1's room. Resident #5 was observed to be inside Resident #1's room for ten minutes before LPN #2 removed Resident #5 from the room. Interview with State Registered Nurse Aide (SRNA) #6 on 12/17/15 at 5:00 PM revealed on 09/01/15 at 7:45 PM she observed Resident #5 in Resident A's room beside Resident A's bed between the two beds, but could not remember if Resident #5 hit Resident A. SRNA #6 stated she took Resident #5 out of the room and reported to the nurse that Resident #5 was in another resident's room again. Interview with Licensed Practical Nurse (LPN) #9 on 12/18/15 at 12:28 PM revealed that he was at the nurses' station on 11/24/15 and Resident #1 and "a bunch of other residents" were sitting around the nurses' station when Resident #5 came up the hall and tried to get through and asked several times for Resident #1 to move and	F 323	On December 23, 2016 the Administrator educated the QA Committee on the F 323 federal regulations of accidents and supervision. The education included, but was not limited to, the definitions of avoidable accidents, unavoidable accidents, assistive devices, resident environment, hazards, risk, supervision/adequate supervision, accurate assessments to determine the amount of supervision that a resident may require for their safety and the safety of those others around them. Between December 29, 2015 and January 3, 2016 the administrator educated all staff related to F 323 accidents and supervision. The education included, but was not limited to: adequate supervision to prevent accidents, reasonable precautions if there is a risk of resident to resident altercations, the facility's responsibility to identify residents who have a history of disruptive or intrusive interactions, or for those residents who exhibit behaviors that make them more likely to be involved in altercations. The facility amended their 24 hour nursing report to include concerns/grievance and resident to resident altercations, behaviors and/or pain as a separate report. The purpose of the amended 24 hour nursing report is to enhance the nurse's recognition of resident grievances/concerns, resident to resident altercations, behaviors and pain.		

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F 323	<p>Continued From page 20</p> <p>then smacked Resident #1 on the shoulder. He said he did not think Resident #5 hit Resident #1 very hard and that Resident #5 was capable of hitting a lot harder. LPN #9 stated he told Resident #5 how physical violence was not appropriate and to ask staff for assistance with getting through the hallway.</p> <p>Interview with SRNA #7 on 12/15/15 at 2:08 PM revealed that she was working on 12/13/15 and said she heard Resident #5 smack Resident #3 but did not see the incident. She stated when she went around the corner, she saw Resident #3 holding Resident #5's hands on the wheelchair so Resident #5 could not hit him/her again. SRNA #7 said she got between the residents and got Resident #3 to let go of Resident #5.</p> <p>Interview with LPN #2 on 12/17/15 at 6:40 PM revealed Resident #5 needed one-on-one supervision at all times due to Resident #5's behaviors of hitting other residents. LPN #2 said the facility was not able to provide the supervision needed for Resident #5. According to LPN #2, there was no excuse for staff to walk by Resident #1's room and not intervene when they saw Resident #5 inside the room. LPN #2 said the facility had not received training on how to care for Resident #5's behaviors.</p> <p>Interview with Resident #3 on 12/15/15 at 9:30 AM revealed that he/she was sitting in the hall waiting on staff to put him/her in bed on 12/13/15 when "out of nowhere" Resident #5 got behind Resident #3's wheelchair and pushed it into the wall almost causing him/her to fall out of the wheelchair. Resident #3 stated that Resident #5 then came around to the side of Resident #3's wheelchair and smacked him/her across the face</p>	F 323	<p>Members of the QA Committee will either interview or conduct head to toe assessment on residents at least quarterly. Interviews will be conducted with those residents who have BIM scores of 8-15 to assess for resident treatment by staff, any concerns about safety, misuse of property, fear of staff, other residents or visitors, dining experience, food quality, activities of daily living care. Those residents with a BIMs of 99 or 7 and below will have a head to toe assessment completed by a nursing member of the QA committee. A minimum of 20 residents per month will be interviewed or have a head to toe skin assessment completed by members of the QA Committee. Each member will report findings five (5) days per week to the QA Committee and will report a cumulative total of interview/body assessment findings to the executive QA Committee quarterly. As indicated any interviews or body assessment findings that could indicate feeling unsafe in the facility, misappropriation of resident property or fear of staff, other residents or visitors will be reported immediately to the administrator, DON for action/interventions and reporting to appropriate state agencies and law enforcement as required.</p>		

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F 323	<p>Continued From page 21</p> <p>on the left side. Resident #3 stated he/she would not let Resident #5 do that again because he/she was going to stay in the room and not come out anymore. Resident #3 stated "I am "afraid" of him/her and nurse aides have bruises from Resident #5 and "I am afraid to sit in the hallway; I enjoyed sitting in the hallway but I am not going out there because of" Resident #5.</p> <p>Interview with LPN #3 on 12/18/15 at 8:30 AM revealed that she had been working at the facility for seven years and was the Quality Assurance (QA) Nurse. LPN #3 stated that she reviewed all incident reports and that Resident #5 wandered all over the building in a wheelchair. LPN #3 reported that on 09/01/15, Resident #5 was trying to get into another resident's bed. The LPN stated she was unaware that Resident #5 had slapped a resident at that time. LPN #3 described another incident on 11/24/15 where there were several residents sitting in the hallway by the nurses' station. Resident #5 was attempting to get through the hallway and smacked Resident #1 on the shoulder. LPN #3 stated the only interventions after this incident were that Resident #5 was educated by staff that physical violence was not appropriate, but stated that due to Resident #5's cognitive status the resident could not be educated. LPN #3 stated she was aware that Resident #5 was involved in another incident with a resident on 12/13/15, but had not completed the review. She stated she implemented 15-minute checks after each incident and reported the incidents to the Director of Nursing (DON) and Administrator. She stated the DON and Administrator then determine when to stop the 15-minute checks.</p> <p>Interview with the DON on 12/18/15 at 12:55 PM</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>revealed that incident reports were initiated by the floor nurses and then sent to Social Services, the DON, and finally to the Administrator. The DON stated the incident reports were to be reviewed within two days of the incident. The DON stated that the QA Nurse and Social Service Worker were responsible for investigating the incidents and initiating interventions. The DON said the incident reports were reviewed in "morning meetings" and the interventions were reviewed. The DON then went on to say she was not aware that Resident #5 had slapped Resident A on 09/01/15 because that information was not on the incident report, but was in a witness statement. The DON stated the care plan should have been updated on 09/01/15 and 11/24/15 when Resident #5 slapped other residents. She stated that residents were usually put on a 15-minute watch after an incident and one-on-one supervision if required. The DON stated if a resident had three incidents of hitting other residents, then the facility would send them out for a psychological evaluation, but the DON stated that she was not aware the resident had three incidents of striking other residents.</p> <p>Interview with the Facility Administrator on 12/18/15 at 1:40-PM revealed she had been employed at the facility for seven days. According to the Administrator, the QA person was responsible for monitoring incident reports and then the Administrator was notified and reviewed them also. The Administrator said the only incident involving Resident #5 that she had reviewed was the one dated 12/13/15. The Administrator said resident care plans should have been updated and appropriate interventions developed after the incidents involving Resident #5. According to the Administrator, if there was a</p>	F 323			

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F 363	<p>Continued From page 24</p> <p>servings/portion sizes; and ask the Dietary Manager if any questions related to dietary services.</p> <p>Review of the policy, "Production Control," dated September 2006, revealed portion control was achieved by utilizing the correct size scoop, ladles, and serving spoons in serving food production. Portion sizes listed on the menu were noted and the spreadsheet would include portion sizes, scoop or dipper size to be used, and therapeutic requirements.</p> <p>Observation on 12/15/15 at 5:40 PM in the kitchen revealed Cook #1 on the serving line using three #12 scoops (1/3 cup) (one in each item) for the pureed Sweet and Sour Pork, Breaded Okra, and Mashed Potatoes.</p> <p>Review of the "Fall and Winter Cycle II 2015 2016" spreadsheet for week one, day three, revealed that a #10 scoop (3/8 cup) was supposed to be used to serve Sweet and Sour Pork and the Breaded Okra. Further review of the spreadsheet revealed a #8 scoop (1/2 cup) was supposed to be used for the Mashed Potatoes.</p> <p>Observation on 12/16/15 at 11:35 AM in the kitchen revealed Cook #2 serving on the tray line using a #12 scoop (1/3 cup) serving pureed Breaded Squash.</p> <p>Review of the "Fall and Winter Cycle II 2015 2016" spreadsheet for week one, day four, revealed that a #10 scoop (3/8 cup) was supposed to be used to serve the pureed Breaded Squash.</p>	F 363	<p>(3) times per day. A feeding tube had been discussed with the resident's family on December 23, 2015. The resident was further assessed by the Registered Dietitian (RD) on December 29, 2016 encouraged fluids and on January 11, 2016 the resident's feeding tube was placed. On January 4, 2016 the resident's weight was 141 pounds and on January 18, 2016 the resident's weight was 148 pounds. A gain of seven (7) pound in two (2) weeks. The resident now has an order to for nothing by mouth (NPO).</p> <p>One (1) resident is care planned for desired weight loss, two (2) of the residents had no significant weight gain/loss and four (4) of the residents had, had a 10% increase in their weight in the last six (6) months.</p> <p>On December 15, 2015, the Dietary Manager (DM) promptly educated Cook # 1. Education included, but was not limited to, checking the spread sheet at each meal service to ensure appropriate scoop/portion sizes, review of the guides on serving/portion sizes, if any uncertainty about sizes of scoops to use consult the DM. On December 16, 2015 the DM promptly educated Cook # 2. The education included, but was not limited to, the "larger" the number on the scoop the "smaller" the portion sizes.</p> <p>On December 23, 2015 the Administrator reviewed regulation F 363 Standard menus and nutritional adequacy with the QA Committee. Dietary Manager was in the QA meeting. The education included, but was not limited to, meeting the nutritional needs of residents in accordance, appropriate scoop equals appropriate portion sizes.</p>	

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F 363	<p>Continued From page 25</p> <p>Interview with Cook #1 on 12/16/15 at 11:56 AM revealed that she looked at the spreadsheet every day and at the recipe book. She stated that it was "an oversight" using the incorrect scoops. Cook #1 further stated, "I know a #10 scoop is bigger than a #12 scoop."</p> <p>Interview with Cook #2 on 12/16/15 at 11:36 AM revealed Cook #2 was using the #12 scoop because they did not have enough of the #10 scoops and she thought a #12 scoop was bigger.</p> <p>Interview with the Dietary Manager on 12/16/15 at 5:30 PM revealed residents would not get all of the food the menu called for if staff did not utilize the proper sized scoops. The Dietary Manager stated she was aware that there were not enough scoops of the correct size.</p> <p>Interview with the Registered Dietitian on 12/16/15 at 12:37 PM revealed that she had not observed cooks using the incorrect scoop size when serving, but they should have been using the scoop size listed on the spreadsheets.</p>	F 363	<p>During the investigative process, the DM realized that the reference guide the cooks were utilizing for portion size/scoops was incorrect and removed the DM did remove the incorrect guide. The dietary staff will be going only on the production sheet for portion/scoop/ladle sizes. The DM ordered three (3) # 8 scoops and three (3) # 10 scoops on December 16, 2015. Upon scoops arrival on December 17, 2015 the DM put the scoops into service.</p> <p>All dietary employees were educated on December 15-16-17, 2015 by the DM. The education included but was not limited to: checking the spread sheet at each meal service to ensure appropriate scoop/portion sizes, review of the guides on serving/portion sizes, the "larger" the number on the scoop the "smaller" the portion sizes, if any questions about portion size and/or scoop size seek advice of the DM.</p> <p>On December 22, 2015, the DM observed 100% of the pureed tray set up. All scoops being utilized for pureed meals were the appropriate sizes.</p> <p>The dietary manager will conduct a QA Audit of two meal services per month for all diets to ensure appropriate scoops, ladles and portion sizes are being provided. DM will document findings and report monthly to the QA committee and quarterly to the executive QA Committee.</p>		