STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325085	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN JUAN CENTER	806 WEST MAPLE STREET FARMINGTON, NM 87401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm** - Actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident's family of any mood, behaviors, adjustment issues or concerns during showers or bathing for 1 (R #59) of 2 (R #59 and #123) residents reviewed for abuse. This deficient practice likely prevented family members from making decisions regarding alternative treatment and advocating on behalf of the resident. The findings are: A. Record review of the Face Sheet dated 11/17/14, revealed the following Diagnosis: [REDACTED]. B. Record review of the Care Plan dated 02/19/15, indicated R #59 has potential for altered mood and behavior i.e. (that is); agitation, sadness, yell/sings loudly, worried, anxious d/t (due to) very confused most of time with Dx (diagnosis) Dementia. Interventions include: Assess and document any mood, behaviors and/or adjustment issues/concerns. Notify MD (medical doctor) and family as needed. C. On 03/19/15 at 10:23 am, during observation, a female could be heard screaming from inside the shower room located near the emergency exit door. The female resident was later identified as R #59. D. On 03/19/15 at 1:58 pm, during interview, Registered Nurse (RN) #2 was asked about R #59 screaming during showers. RN #2 stated, Any time she (R #59) takes a shower, she screams. It doesn't matter who gives the shower, it doesn't matter if it's in the day or evening. She doesn't like water per her family. They said she never cared for bathing. The family doesn't want anything to help calm her, so we are honoring their wishes. The family wants her to have at least two showers a week, and we've discussed it with them. E. On 03/19/15 at 3:44 pm, during interview Family Member #1, was asked if she (Family Member #1) was aware of any issues regarding R #59 during showers. Family Member #1 stated, No. She (R #59) has Alzheimer's and she isn't all there. No one has said anything about that, so I never question it. No one has ever said anything. All they (staff) say at the meetings (referring to care plan meetings for R #59) is 'Everything is okay, everything is fine'. They didn't say anything about her screaming. When Family Member #1 was asked if R #59 had a fear of water, Family Member #1 stated, Not that I know of. When she was here with me she was fine. I don't know when they are showering her if they (staff) are putting water all over her. Maybe how they do it is why she is screaming. No one has asked me or told me about this. I was not aware. When asked if staff talked about medication to help calm R #59 during showers, Family Member #1 stated, No, no one has asked or said anything about that. I've been attending all the meetings (care plan meetings) quarterly. They never brought it up, so I don't know. They say everything is fine and there have been no changes. They never asked or told me, maybe if they did, then we would have talked about it more.
F 0223 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure residents were free from verbal, physical, psychological, and psychosocial abuse in 7 (R #'s 11, 12, 25, 32, 51, 59, and 123) of 7 (R #'s 11, 12, 25, 32, 51, 59, and 123) residents reviewed for abuse and during random observation by: 1) Not investigating complaints of abuse filed by residents and family members for R #11, 12, 25, 32, 51, 59 and 123. 2) Not implementing interventions to ensure that R #59 was not subjected to further psychological harm/distress during showers. This deficient practice has the potential to cause psycological and or physical harm to residents. The findings are: Findings related to abuse complaints/grievances: A. On 03/19/15 at 2:55 pm, during interview the Social Services Director (SSD) explained that grievances or concerns are reviewed by her then she refers them to the appropriate department directors to follow up on. Concerns or issues regarding complaints or grievances are also discussed in the daily morning meeting with Administration and we try to resolve them the same day. B. Record review of facility Grievance/Concern Forms found a grievance form dated 01/20/15 signed by Family Member #3, the daughter of R #123. It stated The night of 01/19/15, Monday night, (name of LPN #2) gave meds to my mom. She was jerking my mom around while giving meds to her. I've seen her do that to other Residents. Why is she working if she is going to be mean to elders? Please do something about it. Thanks for your understanding. C. Record review of the Grievance Log Book dated 01/01/15 to 02/28/15 revealed no resolution date for complaints of abuse made by R #25 and R #123. D. On 03/19/15 at 3:34 pm, during interview the DNS was asked to explain why two complaints of abuse regarding nursing staff that had occurred in January 2015 and February 2015 from R #25 and R #123, had no resolution date documented in the grievance log book. She (DNS) looked through the grievance binder and stated, I can't tell you what happened to these and then stated It wasn't done. C. On 03/19/15 at 3:40 pm, during interview the Clinical Operations Manager confirmed the complaint investigations for (R# 25 and R# 123) had not been completed by stating We didn't do it. D. On 03/19/15 at 5:09 pm, during interview R #12 stated that she has had fights with Licensed Practical Nurse (LPN #2). R #12 stated that LPN #2 has made her cry by telling her (R #12) she can't have snacks. She (LPN #2) pinches and rubs too hard. R #12 stated she had filed 2 grievances against LPN #2 in February 2015 and Registered Nurse (RN #3) was told about it. E. On 03/19/15 at 3:42 pm, during interview the DNS explained that grievances/ allegations of abuse are reported to DOH (Department of Health) and investigated within 72 hours. Any grievances with nursing and certified nursing assistants (CNAs) get personally handled by me. When asked why these grievance/concern issues were not addressed, the DNS stated, I cannot remember seeing one of them, and I think the other one is really a resident to resident issue. The DNS admitted the grievance report regarding R #25 was assigned to her and that it was not completed. F. On 03/19/15 at 5:07 pm, during interview with R #32 when asked if he had ever been mistreated by staff, R #32 nodded his head and stated,Yes the staff treats me badly and sometimes they talk to me badly. The 'skinny one' that comes in the evening, she doesn't treat me good. Sometimes she yells at me and sometimes she keeps saying she is too busy to help me. The staff are good, but 'skinny' is bad and I don't like her. She is mean to everyone sometimes. When asked if R #32 knew who Skinny was, R #32 said No, I call her skinny. G. On 03/20/15 at 9:00 am, during interview RN #2 stated, If any residents or family members have any complaints, I send them to Social Services or have Social Services go down to their rooms. When RN #2 was asked if she could recall any complaints by residents or family members, she (RN #2) stated she would Rather not comment about that. She then stated, Complaints did occur at night, but I would not comment on this. When asked if she knew of any complaints made by residents or family members about LPN #2, RN #2 stated, Yes.her mouth.not her treatment, but what she says. Like saying You're already large enough and you shouldn't eat that. When RN #2 was asked if she had ever received any complaints, she (RN #2) nodded yes and stated, I sent Social Services to the resident's room. H. On 03/20/15 at 9:29 am, during interview the SSD stated, There were no complaints or grievances found for R #12 or R #51 in the grievance book for the present year or all of last year. I. On 03/20/15 at 9:37 am, during interview R #32 confirmed that the Director of Nursing Services (DNS) and Administrator did come and talk to him. When asked what they asked him, he stated, The same as you did. When

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

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

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F 0223 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) asked what he told them he stated, The same as you. Then when asked if he told them about Skinny he stated, Yes.I don't like her. She is bad. J. On 03/20/15 at 9:53 am, during interview with R #32 when presented with a photo ID of LPN #2, R #32 said Yeah.yeah.Skinny, that's her, that's Skinny. K. On 03/20/15 at 11:10 am, during interview, Family Member #2 stated (name of R # 11) complains a lot. To her, it's like they don't want to help her. They have a lot of attitude. They'll say 'I've already helped you. You should be okay.' Maybe they're short-of-staff. When they give her attitude, she gives them attitude back and it goes back and forth. She doesn't give me names. Over the weekend, one of the nurses called me and said 'Your mom is upset and is wanting to leave the facility. She keeps trying to go to the door.' I asked them 'Why is she doing that?' They said, 'She says we're being mean to her and she doesn't want to be here.' After talking to my mom, she said she was in an argument with the nurse. She says they yell at residents. Some of the residents are complaining, saying the staff says, 'Why did you pee on yourself, and why did you poop on yourself.' Most of the times her stories are true and she will defend herself. L. On 03/20/15 at 11:13 am, during interview with the Administrator regarding a grievance report received on 01/02/15 regarding resident R #59, she (Administrator) stated they (Administrator, Social Service Director and DNS) could not find the original grievance report (According to the Grievance/Concern LOG dated January 2015, R #59's family had concerns of a Licenced Nurses attitude and bruising). M. On 03/20/15 at 12:30 pm, during interview Family Member #3 was asked about the grievance form she filed on 01/20/15. She stated that there has not been any response from the facility. She stated that she was visiting R #123 and she (R # 123) didn't want to take her medications. My mother's roommate (R #84) told me that (name of LPN #2) had on another occasion, forced my mother to take her medication when she didn't want to. She had pushed it into my mother's mouth, and made her take it. I asked my mom if this was true, and she said that it was. Family member #3 then stated (Name of LPN #2) is always really rude, so I try not to talk to her when I'm there. When I've asked her questions about my mom, she always just says everything is fine, but doesn't know anything specific. N. On 3/20/15 at 12:50 pm during interview regarding R #51's care, Family Member #4 stated when the family takes R #51out for dinner, LPN #2 would make comments like Here you come, I am sure your sugar is up. FM #4 said she didn't like the comments LPN #2 would make to them and didn't like to be around her (LPN #2). She (LPN #2) shouldn't be doing things like that. No one else ever made comments to me or the family and didn't understand where the comments were coming from. She (LPN #2) would make really unprofessional comments. Family member #4 stated that she did mention it to nursing staff and was told to see Social Services and write out a complaint, but that she had not done so. O. On 03/20/15 at 2:05 pm, during interview the SSD stated, she has had no complaints from R #51 or from Family Member #4, but remembered that Family Member #4 did have a complaint. The SSD couldn't remember what the complaint was about. The Social Service Director was unable to locate or provide the grievance reports from Family Member #4. P. On 03/20/15 at 2:18 pm, during interview with the Administrator and the DNS, when questioned (regarding R #59's grievance report dated 01/02/15 as indicated on the Grievance/Concern Log) the Administrator stated That's the one we don't have. When asked if they recalled a conversation with R #32, the DNS stated that R #32 just told them (DNS and the Administrator) about his (R #32) shingles and no one treated him roughly. The DNS denied that R #32 ever complained about LPN #2. When questioned regarding a grievance (assigned to the DNS as indicated on the grievance form) written and submitted by Family Member #3 of R #123 dated 01/20/15, the DNS stated, I don't know. I got a copy of the grievance (but couldn't talk to it or why it was not investigated). I (DNS) called LPN #2 and she (LPN #2) didn't know of any situation where this happened. There was no documentation provided indicating a conversation/investigation between the DNS and LPN #2 took place. Findings related to Resident #59: Q. Record review of the Face Sheet dated 11/17/14, revealed the following Diagnosis: [REDACTED]. R. Record review of the Care Plan dated 02/19/15, indicated R #59 has potential for altered mood and behavior i.e. (that is); agitation, sadness, yell/sings loudly, worried, anxious d/t (due to) very confused most of time with Dx (diagnosis) Dementia. Interventions include: Assess and document any mood, behaviors and/or adjustment issues/concerns. Notify MD (medical doctor) and Family as needed. S. On 03/19/15 at 10:23 am, during observation, a female could be heard screaming from inside the shower room located near the emergency exit door. The female resident was later identified as R #59. T. On 03/19/15 at 10:25 am, during interview with (CNA) #4, she was asked who was screaming in the shower room. CNA #4 stated, That's (name of R #59). She does that. When asked if she tried to find out why R #59 screams during showers, she stated No. When asked if that's something R #59 does during showers she stated, Yes. When CNA #4 was asked if she asks R #59 if the water is too hot or too cold or if staff is causing her to scream, she stated No. U. On 03/19/15 at 10:34 am, during interview with CNA #5 and CNA #6, both confirmed that R #59 yells out during her showers all the time as soon as the water starts. CNA #5 stated, She does that all the time. CNA #5 and CNA #6 stated that R #59 was yelling because her hair was getting wet. V. On 03/19/15 at 1:58 pm, during interview RN #2 was asked about R #59 screaming during showers. RN #2 stated, Anytime she (R #59) takes a shower, she screams. It doesn't matter who gives the shower, it doesn't matter if it's in the day or evening. She doesn't like water per her family. They said she never cared for bathing. The family doesn't want anything to help calm her, so we are honoring their wishes. To me, it's not a big deal. She (R #59) is not getting hurt, she just doesn't like water. RN #2 confirmed R #59 receives showers twice a week. RN #2 further stated, The family wants her to have at least two showers a week, and we've discussed it with them. RN #2 was asked if R #59 screams for every shower, RN #2 stated Yes. The minute the water is off, she's fine. It's only when the water is on her. Even with the bed bath it (water) bothers her. She absolutely hates it. She was asked if staff has discussed other ways of bathing R #59, RN #2 stated No. The bed bath was as far as it went. W. On 03/19/15 at 2:12 pm, during interview with CNA #5, when asked if R #59 screams during showers, she stated, She has her days. Most of the time, she is yelling. She (R #59) is always cold, so you have to hurry the shower so she won't be yelling. CNA #5 was asked if R #59 refuses showers. She stated Yes. She will say it's cold. When asked if other options have been tried, CNA #5 stated No. She was asked if bed baths have been tried. CNA #5 stated No. We haven't tried that. I think she would fight us more. X. On 03/19/15 at 2:22 pm, during interview with CNA #4, when asked if R #59 screams during her shower, CNA #4 stated All the time. It's a normal thing. She stated I told her already that I was going to give her a shower. She (R #59) said okay. I took her clothes off, put her on the chair, I turned on the water, and I asked if the water was okay. She (R #59) said yes. Then I put shampoo on her hair and when I tried to rinse it, that's when she started screaming. It (R #59's hair) was already soapy and I had to rinse it out. She wasn't really crying, she just does that. When asked if alternatives have been tried, CNA #4 stated She will scream for that too. She will scream for just wetting her. Even if we give her a wet wash cloth to wash her face she screams. CNA #4 was asked if R #59 refuses showers. She stated Sometimes. She is capable of saying no. If she refuses, we ask again and maybe one time she will say yes. We keep trying, if she said no, I would come back and ask her. She will say yes eventually. When I was washing her hair she said stop, but I had to wash the soap out. I did it real quick. It (soap) was in her eyes too, she was wiping her eyes. I could of stopped, but her eyes would of burned. She's fine until she gets wet. Y. On 03/19/15 at 2:40 pm, during interview with CNA #6, she was asked if R #59 screams during showers. She stated Yes. Right when the water hits, she will yell and scream the whole time. CNA #6 confirmed that it happens with every shower. Right when the water hits her is when she starts yelling and screaming. Once the water hits her and even after we start washing her she yells. The first time I had to shower her, I got nervous. When asked if bed baths have been tried, CNA #6 stated I haven't tried to give a bed bath. Z. On 03/19/15 at 3:44 pm, during phone interview Family Member #1 of R #59, was asked if she (Family Member #1) was aware of any issues regarding R #59 during showers. Family Member #1 stated, No. She (R #59) has Alzheimer's and she isn't all there. No one has said anything about that, so I never questioned it. No one has ever said anything. All they (staff) say at the meetings (referring to care plan meetings for R #59) is 'Everything is okay, everything is fine'. They didn't say anything about her screaming. When Family Member #1 was asked if R #59 had a fear of water, Family Member #1 stated, Not that I know of. When she was here with me, she was fine. I don't know when they are showering her if they (staff) are putting water all over her. Maybe how they do it is why she is screaming. No one has asked me or told me about this. I was not aware. When asked if staff talked about medication to help calm R #59 during showers, Family Member #1 stated, No, no one has asked or said anything about that. I've been attending all the meetings (care plan meetings) quarterly. They never brought it up, so I don't know. They say everything is fine and there have been no changes. They never asked or told me, maybe if they did, then we would of talked about it more.
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating**

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F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) **residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** Based on interview and record review, the facility failed to report and investigate allegations of verbal and/or physical abuse to the State Agency within 24 hours for 7 (R #11, 12, 25, 51, 59, 32 and 123) of 7 (R # 11, 12, 25, 51, 59, 32, and 123) residents reviewed for abuse. This failure to report and investigate allegations of abuse had the potential for residents to be subjected to continual mistreatment. The findings are: A. Record review of the Abuse Prohibition Policy and Procedure dated 07/01/13 states: 1. Facility will prohibit abuse, mistreatment, neglect.for all patients through the following: a. Prevention of occurrences b. Identification of possible incidents or allegations which need investigation. c. Investigation of incidents and allegations. d. Protection of patients during investigations. e. Reporting of incidents, investigations, and Center response to the results of their investigations. 2. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect.the Administrator or designee will perform the following. a. Initiate an investigation within 24 hours of an allegation of abuse b. The investigation will be thoroughly documented on the Center's investigation form and log. B. Record review of the Grievance/Concern Policy dated 06/10/13, states Center leadership will investigate, document and follow up on all formal concerns and grievances registered by any patient or patient representative.Upon receipt of the grievance/concern, the Grievance/Concern Form will be initiated by the staff member receiving the concern and documented on the Grievance/Concern Log. Section 4.1.2 states, For reports of abuse, follow the state-specific abuse policy. Section 5 states that the manager will: 1. Contact the person filing the grievance to acknowledge receipt 2. Investigate the grievance 3. Notify the person filing the grievance of resolution within 72 hours. C. On 03/19/15 at 2:55 pm, during interview the Social Services Director (SSD) explained that grievances or concerns are reviewed by her then she refers them to the appropriate department directors to follow up on. Concerns or issues regarding complaints or grievances are also discussed in the daily morning meeting with Administration and we try to resolve them the same day. D. Record review of facility Grievance/Concern Forms found a grievance form dated 01/20/15 signed by Family Member #3, the daughter of R #123. It stated The night of 01/19/15, Monday night, (name of LPN #2) gave meds to my mom. She was jerking my mom around while giving meds to her. I've seen her do that to other Residents. Why is she working if she is going to be mean to elders? Please do something about it. 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She (LPN #2) pinches and rubs too hard. R #12 stated she had filed 2 grievances against LPN #2 in February 2015 and Registered Nurse (RN #3) was told about it. I. On 03/19/15 at 3:42 pm, during interview the DNS explained that grievances/ allegations of abuse are reported to DOH (Department of Health) and investigated within 72 hours. Any grievances with nursing and certified nursing assistants (CNAs) get personally handled by me. When asked why these grievance/concern issues were not addressed, the DNS stated, I cannot remember seeing one of them, and I think the other one is really a resident to resident issue. The DNS admitted the grievance report regarding R #25 was assigned to her and that it was not completed. J. On 03/19/15 at 5:07 pm, during interview with R #32 when asked if he had ever been mistreated by staff, R #32 nodded his head and stated,Yes the staff treats me badly and sometimes they talk to me badly. The 'skinny one' that comes in the evening, she doesn't treat me good. Sometimes she yells at me and sometimes she keeps saying she is too busy to help me. The staff are good, but 'skinny' is bad and I don't like her. She is mean to everyone sometimes. When asked if R #32 knew who Skinny was, R #32 said No, I call her skinny. K. On 03/20/15 at 9:00 am, during interview RN #2 stated, If any residents or family members have any complaints, I send them to Social Services or have Social Services go down to their rooms. When RN #2 was asked if she could recall any complaints by residents or family members, she (RN #2) stated she would Rather not comment about that. She then stated, Complaints did occur at night, but I would not comment on this. When asked if she knew of any complaints made by residents or family members about LPN #2, RN #2 stated, Yes.her mouth.not her treatment, but what she says. Like saying You're already large enough and you shouldn't eat that. When RN #2 was asked if she had ever received any complaints, she (RN #2) nodded yes and stated, I sent Social Services to the resident's room. L. On 03/20/15 at 9:29 am, during interview the SSD stated, There were no complaints or grievances found for R #12 or R #51 in the grievance book for the present year or all of last year. M. On 03/20/15 at 9:37 am, during interview R #32 confirmed that the Director of Nursing Services (DNS) and Administrator did come and talk to him. When asked what they asked him, he stated, The same as you did. When asked what he told them he stated, The same as you. Then when asked if he told them about Skinny he stated, Yes.I don't like her. She is bad. N. On 03/20/15 at 9:53 am, during interview with R #32 when presented with a photo ID of LPN #2, R #32 said Yeah.yeah.Skinny, that's her, that's Skinny. O. On 03/20/15 at 11:10 am, during interview, Family Member #2 stated (name of R # 11) complains a lot. To her, it's like they don't want to help her. They have a lot of attitude. They'll say 'I've already helped you. You should be okay.' Maybe they're short-of-staff. When they give her attitude, she gives them attitude back and it goes back and forth. She doesn't give me names. Over the weekend, one of the nurses called me and said 'Your mom is upset and is wanting to leave the facility. She keeps trying to go to the door.' I asked them 'Why is she doing that?' They said, 'She says we're being mean to her and she doesn't want to be here.' After talking to my mom, she said she was in an argument with the nurse. She says they yell at residents. Some of the residents are complaining, saying the staff says, 'Why did you pee on yourself, and why did you poop on yourself.' Most of the times her stories are true and she will defend herself. P. On 03/20/15 at 11:13 am, during interview with the Administrator regarding a grievance report received on 01/02/15 regarding resident R #59, she (Administrator) stated they (Administrator, Social Service Director and DNS) could not find the original grievance report (According to the Grievance/Concern LOG dated January 2015, R #59's family had concerns of a Licenced Nurses attitude and bruising). Q. On 03/20/15 at 12:30 pm, during interview Family Member #3 was asked about the grievance form she filed on 01/20/15. She stated that there has not been any response from the facility. She stated that she was visiting R #123 and she (R # 123) didn't want to take her medications. My mother's roommate (R #84) told me that (name of LPN #2) had on another occasion, forced my mother to take her medication when she didn't want to. She had pushed it into my mother's mouth, and made her take it. I asked my mom if this was true, and she said that it was. Family member #3 then stated (Name of LPN #2) is always really rude, so I try not to talk to her when I'm there. When I've asked her questions about my mom, she always just says everything is fine, but doesn't know anything specific. R. On 3/20/15 at 12:50 pm during interview regarding R #51's care, Family Member #4 stated when the family takes R #51out for dinner, LPN #2 would make comments like Here you come, I am sure your sugar is up. FM #4 said she didn't like the comments LPN #2 would make to them and didn't like to be around her (LPN #2). She (LPN #2) shouldn't be doing things like that. No one else ever made comments to me or the family and didn't understand where the comments were coming from. She (LPN #2) would make really unprofessional comments. Family member #4 stated that she did mention it to nursing staff and was told to see Social Services and write out a complaint, but that she had not done so. S. On 03/20/15 at 2:05 pm, during interview the SSD stated, she has had no complaints from R #51 or from Family Member #4, but remembered that Family Member #4 did have a complaint. The SSD couldn't remember what the complaint was about. The Social Service Director was unable to locate or provide the grievance reports from Family Member #4. T. On 03/20/15 at 2:18 pm, during interview with the Administrator and the DNS, when questioned (regarding R #59's grievance report dated 01/02/15 as indicated on the Grievance/Concern Log) the Administrator stated That's the one we don't have. When asked if they recalled a conversation with R #32, the DNS stated that R #32 just told them (DNS and the Administrator) about his (R #32) shingles and no one treated him roughly. The DNS denied that R #32 ever complained about LPN #2. When questioned regarding a grievance (assigned to the DNS as indicated on the grievance form) written and submitted by Family Member #3 of R #123 dated 01/20/15, the DNS stated, I don't know. I got a copy of the grievance (but couldn't talk to it or why it was not investigated). I (DNS) called LPN #2 and she (LPN #2) didn't know of any situation where this happened. There was no

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F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) documentation provided indicating a conversation/investigation between the DNS and LPN #2 took place. U. On 03/20/15 at 2:18 pm, during interview with the Administrator and the DNS, when questioned regarding R #59's grievance report dated 01/02/15 as indicated on the Grievance/Concern Log, the Administrator stated That's the one we don't have. When questioned regarding a grievance (assigned to the DNS as indicated on the grievance form) written and submitted by Family Member #3 of R #123 dated 01/20/15, the DNS stated, I don't know. During the interview the DNS could not explain why the above grievance reports were not investigated.
F 0226 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures for prohibiting abuse and mistreatment for 7 (R #11, 12, 25, 32, 51, 59 and 123) of 7 (R #11, 12, 25, 32, 51, 59 and 123) residents reviewed for abuse and during random observation by: 1) Not investigating complaints of abuse filed by residents and family members for R #11, 12, 25, 32, 51, 59 and 123. 2) Not implementing interventions to ensure that R #59 was not subjected to further psychological harm/distress during showers. This deficient practice had the potential to allow residents to be abused, neglected and mistreated, if the facility fails to implement policies and procedures to protect them. The findings are: A. Record review of the Abuse Prohibition Policy and Procedure dated 07/01/13 states: 1. Facility will prohibit abuse, mistreatment, neglect.for all patients through the following: a. Prevention of occurrences b. Identification of possible incidents or allegations which need investigation. c. Investigation of incidents and allegations. d. Protection of patients during investigations. e. Reporting of incidents, investigations, and Center response to the results of their investigations. 2. Actions to prevent abuse.Any staff member who suspects or witnesses an incident of abuse, mistreatment, neglect, injuries of unknown origin .is to tell the abuser to stop immediately and report the incident to his or her supervisor and the DHI immediately. a. If the alleged perpetrator is an employee he or she will be immediately be removed from duty, pending investigation. b. All reports of suspected abuse must also be reported to the patient's family and attending physician. 3. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect.the Administrator or designee will perform the following. a. Initiate an investigation within 24 hours of an allegation of abuse b. The investigation will be thoroughly documented on the Center's investigation form and log. B. Record review of the Grievance/Concern Policy dated 06/10/13 states, Center leadership will investigate, document and follow up on all formal concerns and grievances registered by any patient or patient representative. Social Services personnel will serve as patient advocates in the grievance/concern process.Upon receipt of the grievance/concern, the Grievance/Concern Form will be initiated by the staff member receiving the concern and documented on the Grievance/Concern Log.Section 4.1.2 states, for reports of abuse, follow the state-specific abuse policy.Section 5 states that the manager will: 1. Contact the person filing the grievance to acknowledge receipt 2. Investigate the grievance 3. Notify the person filing the grievance of resolution within 72 hours. C. On 03/19/15 at 2:55 pm, during interview the Social Services Director (SSD) explained that grievances or concerns are reviewed by her then she refers them to the appropriate department directors to follow up on. Concerns or issues regarding complaints or grievances are also discussed in the daily morning meeting with Administration and we try to resolve them the same day. D. Record review of facility Grievance/Concern Forms found a grievance form dated 01/20/15 signed by Family Member #3, the daughter of R #123. It stated The night of 01/19/15, Monday night, (name of LPN #2) gave meds to my mom. She was jerking my mom around while giving meds to her. I've seen her do that to other Residents. Why is she working if she is going to be mean to elders? Please do something about it. Thanks for your understanding. E. Record review of the Grievance Log Book dated 01/01/15 to 02/28/15 revealed no resolution date for complaints of abuse made by R #25 and R #123. F. On 03/19/15 at 3:34 pm, during interview the DNS was asked to explain why two complaints of abuse regarding nursing staff that had occurred in January 2015 and February 2015 from R #25 and R #123, had no resolution date documented in the grievance log book. She (DNS) looked through the grievance binder and stated, I can't tell you what happened to these and then stated It wasn't done. G. On 03/19/15 at 3:40 pm, during interview the Clinical Operations Manager confirmed the complaint investigations for (R# 25 and R# 123) had not been completed by stating We didn't do it. H. On 03/19/15 at 5:09 pm, during interview R #12 stated that she has had fights with Licensed Practical Nurse (LPN #2). R #12 stated that LPN #2 has made her cry by telling her (R #12) she can't have snacks. She (LPN #2) pinches and rubs too hard. R #12 stated she had filed 2 grievances against LPN #2 in February 2015 and Registered Nurse (RN #3) was told about it. I. On 03/19/15 at 3:42 pm, during interview the DNS explained that grievances/ allegations of abuse are reported to DOH (Department of Health) and investigated within 72 hours. Any grievances with nursing and certified nursing assistants (CNAs) get personally handled by me. When asked why these grievance/concern issues were not addressed, the DNS stated, I cannot remember seeing one of them, and I think the other one is really a resident to resident issue. The DNS admitted the grievance report regarding R #25 was assigned to her and that it was not completed. J. On 03/19/15 at 5:07 pm, during interview with R #32 when asked if he had ever been mistreated by staff, R #32 nodded his head and stated,Yes the staff treats me badly and sometimes they talk to me badly. The 'skinny one' that comes in the evening, she doesn't treat me good. Sometimes she yells at me and sometimes she keeps saying she is too busy to help me. The staff are good, but 'skinny' is bad and I don't like her. She is mean to everyone sometimes. When asked if R #32 knew who Skinny was, R #32 said No, I call her skinny. K. On 03/20/15 at 9:00 am, during interview RN #2 stated, If any residents or family members have any complaints, I send them to Social Services or have Social Services go down to their rooms. When RN #2 was asked if she could recall any complaints by residents or family members, she (RN #2) stated she would Rather not comment about that. She then stated, Complaints did occur at night, but I would not comment on this. When asked if she knew of any complaints made by residents or family members about LPN #2, RN #2 stated, Yes.her mouth.not her treatment, but what she says. Like saying You're already large enough and you shouldn't eat that. When RN #2 was asked if she had ever received any complaints, she (RN #2) nodded yes and stated, I sent Social Services to the resident's room. L. On 03/20/15 at 9:29 am, during interview the SSD stated, There were no complaints or grievances found for R #12 or R #51 in the grievance book for the present year or all of last year. M. On 03/20/15 at 9:37 am, during interview R #32 confirmed that the Director of Nursing Services (DNS) and Administrator did come and talk to him. When asked what they asked him, he stated, The same as you did. When asked what he told them he stated, The same as you. Then when asked if he told them about Skinny he stated, Yes.I don't like her. She is bad. N. On 03/20/15 at 9:53 am, during interview with R #32 when presented with a photo ID of LPN #2, R #32 said Yeah.yeah.Skinny, that's her, that's Skinny. O. On 03/20/15 at 11:10 am, during interview, Family Member #2 stated (name of R # 11) complains a lot. To her, it's like they don't want to help her. They have a lot of attitude. They'll say 'I've already helped you. You should be okay.' Maybe they're short-of-staff. When they give her attitude, she gives them attitude back and it goes back and forth. She doesn't give me names. Over the weekend, one of the nurses called me and said 'Your mom is upset and is wanting to leave the facility. She keeps trying to go to the door.' I asked them 'Why is she doing that?' They said, 'She says we're being mean to her and she doesn't want to be here.' After talking to my mom, she said she was in an argument with the nurse. She says they yell at residents. Some of the residents are complaining, saying the staff says, 'Why did you pee on yourself, and why did you poop on yourself.' Most of the times her stories are true and she will defend herself. P. On 03/20/15 at 11:13 am, during interview with the Administrator regarding a grievance report received on 01/02/15 regarding resident R #59, she (Administrator) stated they (Administrator, Social Service Director and DNS) could not find the original grievance report (According to the Grievance/Concern LOG dated January 2015, R #59's family had concerns of a Licenced Nurses attitude and bruising). Q. On 03/20/15 at 12:30 pm, during interview Family Member #3 was asked about the grievance form she filed on 01/20/15. She stated that there has not been any response from the facility. She stated that she was visiting R #123 and she (R # 123) didn't want to take her medications. My mother's roommate (R #84) told me that (name of LPN #2) had on another occasion, forced my mother to take her medication when she didn't want to. She had pushed it into my mother's mouth, and made her take it. I asked my mom if this was true, and she said that it was. Family member #3 then stated (Name of LPN #2) is always really rude, so I try not to talk to her when I'm there. When I've asked her questions about my mom, she always just says everything is fine, but doesn't know anything specific. R. On 3/20/15 at 12:50 pm during interview regarding R #51's care, Family Member #4 stated when the family takes R #51out for dinner, LPN #2 would make comments like Here you come, I am sure your sugar is up. FM #4 said she didn't like the comments LPN #2 would make to them and didn't like to be around her (LPN #2). She (LPN #2) shouldn't be doing things like that. No one else ever made comments to me or the family and didn't understand where the comments were

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F 0226 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) coming from. She (LPN #2) would make really unprofessional comments. Family member #4 stated that she did mention it to nursing staff and was told to see Social Services and write out a complaint, but that she had not done so. S. On 03/20/15 at 2:05 pm, during interview the SSD stated, she has had no complaints from R #51 or from Family Member #4, but remembered that Family Member #4 did have a complaint. The SSD couldn't remember what the complaint was about. The Social Service Director was unable to locate or provide the grievance reports from Family Member #4. T. On 03/20/15 at 2:18 pm, during interview with the Administrator and the DNS, when questioned (regarding R #59's grievance report dated 01/02/15 as indicated on the Grievance/Concern Log) the Administrator stated That's the one we don't have. When asked if they recalled a conversation with R #32, the DNS stated that R #32 just told them (DNS and the Administrator) about his (R #32) shingles and no one treated him roughly. The DNS denied that R #32 ever complained about LPN #2. When questioned regarding a grievance (assigned to the DNS as indicated on the grievance form) written and submitted by Family Member #3 of R #123 dated 01/20/15, the DNS stated, I don't know. I got a copy of the grievance (but couldn't talk to it or why it was not investigated). I (DNS) called LPN #2 and she (LPN #2) didn't know of any situation where this happened. There was no documentation provided indicating a conversation/investigation between the DNS and LPN #2 took place. U. On 03/20/15 at 2:18 pm, during interview with the Administrator and the DNS, when questioned regarding R #59's grievance report dated 01/02/15 as indicated on the Grievance/Concern Log, the Administrator stated That's the one we don't have. When questioned regarding a grievance (assigned to the DNS as indicated on the grievance form) written and submitted by Family Member #3 of R #123 dated 01/20/15, the DNS stated, I don't know. During the interview the DNS could not explain why the above grievance reports were not investigated. Findings related to Resident #59: V. Record review of the Face Sheet dated 11/17/14, revealed the following Diagnosis: [REDACTED]. W. Record review of the Care Plan dated 02/19/15, indicated R #59 has potential for altered mood and behavior i.e. (that is); agitation, sadness, yell/sings loudly, worried, anxious d/t (due to) very confused most of time with Dx (diagnosis) Dementia. Interventions include: Assess and document any mood, behaviors and/or adjustment issues/concerns. Notify MD (medical doctor) and Family as needed. X. On 03/19/15 at 10:23 am, during observation, a female could be heard screaming from inside the shower room located near the emergency exit door. The female resident was later identified as R #59. Y. On 03/19/15 at 10:25 am, during interview with (CNA) #4, she was asked who was screaming in the shower room. CNA #4 stated, That's (name of R #59). She does that. When asked if she tried to find out why R #59 screams during showers, she stated No. When asked if that's something R #59 does during showers she stated, Yes. When CNA #4 was asked if she asks R #59 if the water is too hot or too cold or if staff is causing her to scream, she stated No. Z. On 03/19/15 at 10:34 am, during interview with CNA #5 and CNA #6, both confirmed that R #59 yells out during her showers all the time as soon as the water starts. CNA #5 stated, She does that all the time. CNA #5 and CNA #6 stated that R #59 was yelling because her hair was getting wet. AA. On 03/19/15 at 1:58 pm, during interview RN #2 was asked about R #59 screaming during showers. RN #2 stated, Anytime she (R #59) takes a shower, she screams. It doesn't matter who gives the shower, it doesn't matter if it's in the day or evening. She doesn't like water per her family. They said she never cared for bathing. The family doesn't want anything to help calm her, so we are honoring their wishes. To me, it's not a big deal. She (R #59) is not getting hurt, she just doesn't like water. RN #2 confirmed R #59 receives showers twice a week. RN #2 further stated, The family wants her to have at least two showers a week, and we've discussed it with them. RN #2 was asked if R #59 screams for every shower, RN #2 stated Yes. The minute the water is off, she's fine. It's only when the water is on her. Even with the bed bath it (water) bothers her. She absolutely hates it. She was asked if staff has discussed other ways of bathing R #59, RN #2 stated No. The bed bath was as far as it went. BB. On 03/19/15 at 2:12 pm, during interview with CNA #5, when asked if R #59 screams during showers, she stated, She has her days. Most of the time, she is yelling. She (R #59) is always cold, so you have to hurry the shower so she won't be yelling. CNA #5 was asked if R #59 refuses showers. She stated Yes. She will say it's cold. When asked if other options have been tried, CNA #5 stated No. She was asked if bed baths have been tried. CNA #5 stated No. We haven't tried that. I think she would fight us more. CC. On 03/19/15 at 2:22 pm, during interview with CNA #4, when asked if R #59 screams during her shower, CNA #4 stated All the time. It's a normal thing. She stated I told her already that I was going to give her a shower. She (R #59) said okay. I took her clothes off, put her on the chair, I turned on the water, and I asked if the water was okay. She (R #59) said yes. Then I put shampoo on her hair and when I tried to rinse it, that's when she started screaming. It (R #59's hair) was already soapy and I had to rinse it out. She wasn't really crying, she just does that. When asked if alternatives have been tried, CNA #4 stated She will scream for that too. She will scream for just wetting her. Even if we give her a wet wash cloth to wash her face she screams. CNA #4 was asked if R #59 refuses showers. She stated Sometimes. She is capable of saying no. If she refuses, we ask again and maybe one time she will say yes. We keep trying, if she said no, I would come back and ask her. She will say yes eventually. When I was washing her hair she said stop, but I had to wash the soap out. I did it real quick. It (soap) was in her eyes too, she was wiping her eyes. I could of stopped, but her eyes would of burned. She's fine until she gets wet. DD. On 03/19/15 at 2:40 pm, during interview with CNA #6, she was asked if R #59 screams during showers. She stated Yes. Right when the water hits, she will yell and scream the whole time. CNA #6 confirmed that it happens with every shower. Right when the water hits her is when she starts yelling and screaming. Once the water hits her and even after we start washing her she yells. The first time I had to shower her, I got nervous. When asked if bed baths have been tried, CNA #6 stated I haven't tried to give a bed bath. EE. On 03/19/15 at 3:44 pm, during phone interview Family Member #1 of R #59, was asked if she (Family Member #1) was aware of any issues regarding R #59 during showers. Family Member #1 stated, No. She (R #59) has Alzheimer's and she isn't all there. No one has said anything about that, so I never questioned it. No one has ever said anything. All they (staff) say at the meetings (referring to care plan meetings for R #59) is 'Everything is okay, everything is fine'. They didn't say anything about her screaming. When Family Member #1 was asked if R #59 had a fear of water, Family Member #1 stated, Not that I know of. When she was here with me, she was fine. I don't know when they are showering her if they (staff) are putting water all over her. Maybe how they do it is why she is screaming. No one has asked me or told me about this. I was not aware. When asked if staff talked about medication to help calm R #59 during showers, Family Member #1 stated, No, no one has asked or said anything about that. I've been attending all the meetings (care plan meetings) quarterly. They never brought it up, so I don't know. They say everything is fine and there have been no changes. They never asked or told me, maybe if they did, then we would of talked about it more.
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** Based on interview and observation, the facility failed to provide care and services that promote resident's dignity for 14 (R #'s 4, 14, 21, 22, 25, 29, 30, 32, 49, 57, 79, 81, 85 and 98) of 14 (R #'s 4, 14, 21, 22, 25, 29, 30, 32, 49, 57, 79, 81, 85 and 98) residents reviewed for dignity and random observation during dining by: 1. Not serving dinner to R #25 at the same time as their table mate R #10. Resident #25 had to wait 30 minutes to be served. 2. Resident #'s 4, 14, 21, 49, 79, 81, 85 and 98 who receive total assistance from staff with ADL's (activities of daily living) and need to be cued to eat, had to wait 30 minutes to be fed, while staff passed out trays. 3. Not ensuring that urinary catheter bags are covered for R #30 and R #32. This deficient practice has the potential to prevent residents from maintaining their highest level of dignity and psychosocial well being. The findings are: Findings related to dining are: A. On 03/16/15 at 6:00 pm, during observation in dining room one, R #25 waited 30 minutes for his tray while his table mate R#10 was served his tray and ate. B. Record review of Medical Record for residents # 4, 14,21, 49, 79, 81, 85 and 98, indicated they (residents) needed assistance with all their ADLs (activities of Daily Living) that included eating. The residents are not able to pickup the utensils to feed themselves, due to having contractors of their arms/hands. Residents made no attempts to feed themselves. C. On 03/25/15 at 10:01 am, during interview, Restorative Aide #1 was asked if she would point out the residents on the dining chart that were total care and needed cueing to eat. She doubled checked the chart and stated Residents 4, 14, 21, 22, 29, 49, 57, 79, 81, 85 and 98 were all total assist, but there are a few that need prompting (referring to cueing). They are seated at tables with the residents that staff can assist and cue. Findings for R (#'s 4, 14, 21, 25, 29, 49, 57, 79, 81, 85 and 98): D. On 03/16/15 at 6:00 pm, during observation in the dining room three (that started at 5:30 pm), R #4, 14, 21, 49, 79, 81, 85 and 98 had to wait 30 minutes for staff to assist residents as they are not able to do their own ADL's without the assistance of staff (CNA's). Residents # 25, 29 and 57 had to wait 30 minutes for all trays to be passed

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F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) out, before staff could prompt/cue them to eat. Findings for R #30 and 32 regarding catheters: E. On 03/16/15 at 1:46 pm, during observation, Resident #32's catheter bag was hooked under the wheelchair with no covering. F. On 03/17/15 at 11:32 am, during observation, R #32 was observed in the dining/activity room with the catheter bag secured beneath the wheelchair with no covering. G. On 03/20/15 at 10:01 am, during interview with Licensed Practical Nurse (LPN) #1, she stated, Catheter bags should be covered when a resident is in public. H. On 03/20/15 at 10:19 am, during interview with Registered Nurse (RN) #3, she stated, We do have covers that are used to cover bags. I. On 03/20/15 at 11:10 am, during interview with the Director of Nursing Services (DNS), she stated It is expected that the catheter bag is covered and secured. J. On 03/20/15 1:40 pm, during interview with R #30, she stated that the staff don't cover her catheter bag when she is up in the wheelchair out of her room.
F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** Based on record review and interview, the facility failed to ensure that residents were given the choice of the frequency of their baths/showers for 1 (R #30) of 3 (R #'s 13, 30 and 52) residents reviewed for choices. This deficient practice has the potential to diminish the quality of life for the resident by failing to provide a respectful environment that allows the resident to exercise his/her autonomy regarding important facets of his/her life. The findings are: A. Record review of the Weekly Bath and Skin Report log book for the months of October 2014 through March 2015 revealed no documentation related to R #30. B. Record review of Resident #30's Activities of Daily Living (ADL) sheets for January 2015 through March 2015 indicated that: 1. For the month of January 2015, resident missed 2 out of 10 scheduled showers. 2. For the month of February 2015, resident missed 4 out of 8 scheduled showers. 3. For the month of March 2015, resident missed 1 out of 5 scheduled showers. C. Record review of nurses notes for the months of January 2015 through March 2015, revealed the following: 1. No documentation indicating that the resident refused showers. 2. No documentation on whether alternatives for bathing were offered. 3. No documentation on whether alternate dates were offered. D. On 03/19/15 at 10:40 am, during interview Resident #30, stated that she had requested more frequent showers. She also stated that they say they (the facility) are short staffed. E. On 03/19/15 at 11:45 am, during interview the Director of Nursing Service (DNS) stated that she was unaware that baths were not routinely being documented on the Weekly Bath and Skin Report. She also stated that if a resident refused a bath, The aide would let the nurse know and it should be documented in the nurse's notes.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to consistently provide an ongoing program of activities designed to meet the interests and promote physical, mental, and psychosocial well-being for 4 (R #'s 4, 102, 106 and 123) of 5 (R#'s 4, 76, 102, 106 and 123) residents sampled for activities who were incapable of participating in group activities, in accordance with their care plans. This deficient practice has the potential to result in the residents' failure to achieve their highest physical and psychosocial levels of well-being, through decreased stimulation and social interaction. The findings are: Findings for R #4: A. Record review of the Care Plan for R #4 found a focus area stating Decreased activity participation characterized by little or no involvement, lack of attendance related to: impaired communication, cognitive impairment. Goals related to this focus area included (Name of R #4) will receive sensory stimulation as needed. (Name of R #4) will participate in Level III one-on-one activity programs 3 times a week as tolerated. The date initiated for the Care Plan section was noted to be 11/30/11. B. Record review of Interdisciplinary Team Notes for R #4 dated 02/12/15 with the heading Quarterly Care Meeting, which included the statements Resident 1:1 room visits on Tuesday, Thursday, and Saturdays and Resident does smile at times when spoken to. C. Record review of the Recreation Quarterly Progress Note dated 02/12/15 found the statement, Participates in individual intervention program? Yes. 3x (three times) weekly 1:1 room visits. Participation level is noted to be passive. D. Record review of the One-to-One Activity Participation logs provided by the Activities Aide on 03/20/15 at 10:25 am, after being requested on 03/20/15 at 9:20 am, revealed: 1. On the logs for the month of December 2014 and January 2015, participation was documented on every Tuesday, Thursday and Saturday. Rather than initialing each entry as it was completed however, the Activities Aide initialed the first entry only, and then drew a line to indicate her initials for the remainder of the month. 2. On the log for the month of February 2015, the activities aide had used the numeral 1 to indicate February. This error occurred on each entry throughout the month, and in each case was corrected with a number 2 written over the number 1. The activity aide's initials were again written on the top line only, and then drew a line to indicate that she had performed the activity on each Tuesday, Thursday and Saturday for the remaider of the month. E. Record review of the Employee Time Cards for the Activities Aide, indicated that she had not worked on 9 of the dates on which the One-to-One Activities Participation Logs indicated that she had performed activities with R #4 (12/20/14, 12/25/14, 12/27/14, 01/01/15, 01/03/15, 01/06/15, 01/08/15, 02/10/15 and 02/17/15). Notations on the Time Cards variously list reasons for absence such as Holiday, Bonus Holiday, and Hourly Sick, for some dates, while others do not give reasons but do not show times clocked in and out. F. On 03/24/15 at 9:05 am, during interview with the Vice President of Operations, he verified that days on Employee Time Cards which do not contain clock in and out times are days on which an employee did not work. He stated that the Activities Aide was not presently in the building or available for an interview due to having been called out-of-state on an emergency. G. On 03/25/15 at 1:10 pm, during interview with the Activities Director, she stated that the presence of the Activities Aide's initials on the One-to-One Activities Participation Logs indicated that the Activities Aide personally performed the listed activity. When advised that the Activities Aide had not worked on 9 days for which she had made entries on the logs, the Activities Director was unable to explain the discrepancy. H. On 03/25/15 at 1:35 pm during interview with the Activites Director, when asked for the Activity Participation Logs for R #4 for September, October and November 2014, she confirmed that she was unable to locate them. Findings for R #102 and R #106: I. Record review of the care plans for R #102 and R #106 indicated that they were to receive 1:1 activities three times weekly. J. On 03/24/15 at 1:10 pm, during interview with the Activities Director, she was asked to provide One-to-One Participation Logs for both residents for January-March 2015. She produced activity logs for the months of February and March 2015. K. On 03/24/15 at 1:35 pm, during follow-up interview with the Activities Director, she stated that she was unable to locate a One-to-One Activities Participation Log for the month of January 2015 for either resident. L. Record review of the 1:1 Activity logs dated 02/01/15 to 03/21/15 found that 1:1 activities had been performed on four occasions each month for R #102 and R #106. Scheduled activity dates for which activities did not occur variously list the reasons of sleeping, or choose (sic) not to attend, or are left blank. Findings for R #123: M. Record review of Face Sheet for R #123 revealed the following Diagnosis: [REDACTED]. N. Record review of Care Plan dated 12/29/14, indicated Resident exhibits or is at risk for limited meaningful engagement related to cognitive loss/loss of function, adjustment to placement, loss of motivation and initiation. Interventions for R #123 include: establish a relationship with resident via one to one interventions and provide one to one 3 times per week. O. Record review of the One-to-One Activity Participation Log dated 02/02/15 through 02/27/15, indicated R #123 received one-to-one visits four times during the month of February 2015. On eight separate occasions, one-to-one visits did not occur when scheduled. The reason listed is Choose (sic) not to attend or they are left blank. P. Record review of the One-to-One Activity Participation Log dated 03/02/15 through 03/30/15, indicated R #123 received one-to-one visits three times. On three occasions, one-to-one visits did not occur when scheduled. The reason listed is Choose (sic) not to attend or they are left blank. Q. Record review of Individual Program Planning Policy dated 07/01/14 indicated Regularly scheduled programming will be provided to all residents.to ensure that all residents/patients who have limited tolerance or prefer not to participate in group programs have consistent and individualized recreation opportunities. R. On 03/19/15 at 9:38 am, during interview the Activities Aide confirmed R #123 is scheduled to receive one-to-one room visits three times a week: on Monday, Wednesday, and Friday. When the Activities Aide was asked about one-to-one visits for R #123, she stated I don't do room visits on Monday. When asked who is responsible for doing room visits, the Activities Aide stated Just me. It's a lot and sometimes I get behind. The Activities Aide was asked if anybody does room visits on Mondays, she stated, No. I don't think so. When asked about the entries on the One-to-One Activity Participation Log, the Activities Aide stated, It was marked wrong. The check marks are not supposed to be there. The Activities Aide confirmed the boxes for

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	325085	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) 02/02/15 and 03/02/15 should not be checked, stating They shouldn't be there. When asked if R #123 was receiving one-to-one visits three times a week in February, the Activities Aide state, No. Twice a week. Monday is my day off. When asked if R #123 was getting one-to one visits in March, the Activities Aide stated, No, it's still the same. It's still twice a week. On Fridays both (name of Activities Director) and I do outings, so we don't do room visits on Fridays. So it's one day a week. Activites Aide confirmed that R #123 has only been receiving one-to-one room visits one day each week. S. On 03/19/15 at 3:26 pm, during interview the Activities Director stated R #123 is scheduled for one-to-one visits three times a week on Monday, Wednesday, and Fridays. The Activities Director confirmed that the documentation represents R #123 is only receiving one-to-one visits once a week for both February and March. The Activities Director further confirmed the care plan for R #123 is not being followed.
F 0250 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that needed social services were provided for 1 (R #13) of 1 (R #13) resident reviewed for social services by not assessing and meeting the needs of a resident who was grieving. This deficient practice had the potential to cause the resident excessive suffering during the month following her bereavement, as she had few opportunities to talk about her grief. The findings are: A. Record review of Interdisciplinary Progress Notes for R #13 found: 1. A note dated [DATE] stating, Resident agitated. Resident saying that (husband's name) has not returned phone calls for 2 days. Resident said spouse was supposed to visit resident yesterday and didn't visit.at 1100 hours (11:00 am) (resident's granddaughter) contacted facility that spouse passed away at house. 2. A note dated [DATE] stating, .Resident gets emotional but dealing okay with death of spouse. Does mention it to staff. Will continue to assess. 3. No subsequent notes concerning the resident's emotional status were found. B. Record review of Social Service notes for R #13 found an entry dated [DATE] stating Resident spouse had passed away; so granddaughter was here to notify resident that he passed on. Resident said I'm sure you already know my husband died she said. Offer condolence, sympathy to resident and she said it's alright, we just need to get thru (sic) the funeral etc. Resident eyes were red, but did not show emotions. Told resident if she need (sic) to talk I'm here for her. Subsequent Social Service notes related to the resident's grieving were not found. C. Record review of Social Services Assessments for R #13 found that the most recent assessment was dated [DATE]. The assessment states Family/Support System: No change in family support. Spouse continues to visit often. Typical mood: Mood unstable. Increase /decrease per spouse. Nothing was found to indicate that the resident's support needs had been reassessed following her husband's death. D. On [DATE] at 4:35 pm, during interview with R #13, she was asked what support the facility had given her following the death of her husband, and she stated, None. She was asked whether anyone from Social Services had spoken with her regarding her grieving process, and she stated, No. I didn't know I could ask them about it. But they haven't said anything to me. She was asked whether the Nurses or Certified Nurse Aides (CNAs) had asked her how she was coping, and she stated, No. E. On [DATE] at 4:31 pm, during an interview with CNA #1, she was asked about her interactions with R #13. She stated, She pretty much keeps to herself. Her husband passed away recently, and she's been sad about it. Mostly she'll keep to herself, but sometimes she'll ask for us to just sit with her and watch TV, but she understands that we're busy and we can't usually do that. CNA #1 was asked if she had received any training, or if there had been any facility discussions about how to help the resident in her grief, and she stated, Not really. It's just the CNAs passing it along from shift-to-shift that she lost her husband and likes to keep to herself. F. On [DATE] at 8:31 am, during an interview with Licensed Practical Nurse (LPN) #1, he was asked about the facility response to support the resident following the death of her husband. He stated, The family has been involved. Her nephews have been coming. We have a psych eval (psychological evaluation) set up for her in a couple of months. So she can talk to a counselor then. Mostly it has just been the family. G. On [DATE] at 9:50 am, during an interview with the Social Services Director, she stated When we found out he had died , her granddaughter and son-in-law came in, and she was brought into my office and told that he had died . I was shocked that she was calm and said she would be okay. She goes to counseling every ,[DATE] months. She's scheduled for June. The Social Services Director was asked to review the resident's Social Service notes, and her attention was called to the lack of notes after the resident had been told of her husband's death. She stated I thought I documented it. Probably the grieving part should be in there. I can put that in for her.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the care plan for 1 resident (R #13) of 1 resident (R #13) reviewed for Social Services. This deficient practice had the potential to cause the resident excessive suffering during the month following her bereavement, as she had few opportunities to share and process her grief. The findings are: A. Record review of Social Service notes for R #13 found an entry dated [DATE] stating Resident spouse had passed away; so granddaughter was here to notify resident that he passed on. Resident said I'm sure you already know my husband died she said. Offer condolence, sympathy to resident and she said it's alright, we just need to get thru (sic) the funeral etc. Resident eyes were red, but did not show emotions. Told resident if she need (sic) to talk I'm here for her. Subsequent Social Service notes related to the resident's grieving were not found. B. Record review of Social Services Assessments for R #13 found that the most recent assessment was dated [DATE]. The assessment states Family/Support System: No change in family support. Spouse continues to visit often. Typical mood: Mood unstable. Increase /decrease per spouse. Nothing was found to indicate that the resident's support needs had been reassessed following her husband's death. C. Record review of R #13's care plan found no entries indicating that the care plan had been updated following her husband's death. A focus area on the care plan stated Argues/disagrees with spouse and express (sic) feelings of persecution. D. On [DATE] at 4:35 pm, during interview with R #13, she was asked what support the facility had given her following the death of her husband, and she stated, None. She was asked whether anyone from Social Services had spoken with her regarding her grieving process, and she stated, No. I didn't know I could ask them about it. But they haven't said anything to me. She was asked whether the nurses or Certified Nurse Aides (CNAs) had asked her how she was coping, and she stated, No. E. On [DATE] at 4:31 pm, during an interview with CNA #1, she was asked about her interactions with R #13. She stated, She pretty much keeps to herself. Her husband passed away recently, and she's been sad about it. Mostly she'll keep to herself, but sometimes she'll ask for us to just sit with her and watch TV, but she understands that we're busy and we can't usually do that. CNA #1 was asked if she had received any training, or if there had been any facility discussions about how to help the resident in her grief, and she stated, Not really. It's just the CNAs passing it along from shift-to-shift that she lost her husband and likes to keep to herself. F. On [DATE] at 8:31 am, during an interview with Licensed Practical Nurse (LPN) #1, he was asked about the facility response to support the resident following the death of her husband. He stated, The family has been involved. Her nephews have been coming. We have a psych eval (psychological evaluation) set up for her in a couple of months. So she can talk to a counselor then. Mostly it has just been the family. G. On [DATE] at 9:50 am, during an interview with the Social Services Director, she stated When we found out he had died , her granddaughter and son-in-law came in, and she was brought into my office and told that he had died . I was shocked that she was calm and said she would be okay. She goes to counseling every ,[DATE] months. She's scheduled for June. The Social Services Director was asked about the lack of an updated assessment or care plan, and that no follow-up Social Service notes were found after the resident had been told of her husband's death. She stated I thought I documented it. Probably the grieving part should be in there. I can put that in for her.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This is a repeat deficiency from previous survey Based on record review and interview, the facility failed to implement the Care Plan for 2 (R# 106 and 123) of 2 (R # 106 and 123) residents reviewed for (Gastrointestinal feeding tube) G tube feeding and activities by: 1. Staff failing to implement specific interventions, regarding treatment and assessment of the feeding tube insertion site, from the care plan and transfer interventions to the Treatment and Rehabilitation Form (TAR) for R #106. 2. Not providing one-to-one services regarding activities three times a week for R #123. If the facility is not

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F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) implementing care plans, then the residents may not receive adequate care needed to maintain their highest level of well-being. The findings are: The findings for R #106 are: A. Record review of the Care plan dated 12/13/14 regarding R #106's feeding tube/ G tube indicated, Assess skin around G tube site, skin care and dressing as ordered. B. On 03/23/15 at 3:56 pm, during interview with Registered Nurse (RN #3), stated The nurses do a daily assessment of the peg tube (a type of feeding tube)site and I am called to look at the site if there is any problems with it. C. Record review of R #106's TAR dated March 2015 had no notation for G tube site skin assessment, treatment or dressing changes. D. On 03/23/15 at 4:15 pm, during interview RN #2 confirmed and stated that, Skin checks or dressing change at peg tube site for R #106 was not included in the residents (R #106) TAR. E. On 03/24/15 at 9:54 am, during interview RN #3 stated, If you have a peg tube (feeding tube) we (nurses) are going to get an order from the physician regarding care of the feeding tube. It is standard practice to assess the peg tube site each nursing shift and it is part of our skin assessments. When asked where this assessment would be documented RN #3 stated, The assessment would be noted in the TAR. When asked as the clinical educator what her expectations were, RN #3 stated, If it is noted on the Care Plan, I would expect to see it on the TAR. Our Minimum Data Set (MDS) coordinator follows up and checks to see that the TARs match the Care plans. F. Record review of R #106's Nursing Assessment/skin assessment (not dated) had no documentation or notation indicating a G tube was present. G. On 03/24/15 at 2:40 pm, during interview the MDS Coordinator stated, I look at the TAR and review the care plan as well. I check to see if treatments reflect the care plan. I review the care plans every three months. The nurses get the order and put the order in the chart. Then a new TAR is printed and followed up on by RN #3 or the Director of Nursing Services (DNS) may do it. H. On 03/24/15 at 2:51 pm, during interview RN #3 confirmed that she (RN #3) would be following up on any new treatment orders. RN #3 then confirmed her prior statement that documentation of G Tube care is to be noted on the TAR and that the TAR should reflect the residents plan of care. RN #3 was asked why R #106, who was admitted to the facility on [DATE], had no documentation or notations indicating any assessment, cleansing or dressing changes of R #106's G tube site since her admitted , RN #3 stated she was Not sure how this was overlooked and apologized for the lack of documentation. Findings for R #123 regarding one-to-one services: I. Record review of Care Plan dated 12/29/14, indicated Resident exhibits or is at risk for limited meaningful engagement related to cognitive loss/loss of function, adjustment to placement, loss of motivation and initiation. Interventions for R #123 include: establish a relationship with resident via one to one interventions and provide one-to-one 3 times per week. J. On 03/19/15 at 9:38 am, during interview the Activities Aide confirmed R #123 is scheduled to receive one-to-one room visits three times a week: on Monday, Wednesday, and Friday. When the Activities Aide was asked about one-to-one visits for R #123, she stated I don't do room visits on Monday. When asked who is responsible for doing room visits, the Activities Aide stated Just me. It's a lot and sometimes I get behind. The Activities Aide was asked if anybody does room visits on Mondays, she stated, No. I don't think so. When asked about the entries on the One-to-One Activity Participation Log, the Activities Aide stated, It was marked wrong. The check marks are not supposed to be there. The Activities Aide confirmed the boxes for 02/02/15 and 03/02/15 should not be checked, stating They shouldn't be there. When asked if R #123 was receiving one-to-one visits three times a week in February, the Activities Aide state, No. Twice a week. Monday is my day off. When asked if R #123 was getting one-to one visits in March, the Activities Aide stated, No, it's still the same. It's still twice a week. On Fridays both (name of Activities Director) and I do outings, so we don't do room visits on Fridays. So it's one day a week. Activites Aide confirmed that R #123 has only been receiving one-to-one room visits one day each week. K. On 03/19/15 at 3:26 pm, during interview the Activities Director stated R #123 is scheduled for one-to-one visits three times a week on Monday, Wednesday, and Fridays. The Activities Director confirmed that the documentation represents R #123 is only receiving one-to-one visits once a week for both February and March. The Activities Director further confirmed the care plan for R #123 is not being followed.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on interview, observation and record review the facility failed to ensure that residents are free from accidents by not providing interventions to minimize or prevent falls for 1 (R #106) of 1 (R #106) resident assessed to be at risk for falls. If interventions to prevent falls are not being implemented, then residents are at further risk of falls and injuries related to falls.The findings are: A. Record review of the Nursing note for R #106 revealed: 1. The resident had fallen out of bed on 03/07/15. 2. There was a bruise noted to the right outer elbow on 03/08/15. 3. 03/09/15 indicated staff was doing the last round with residents before shift change and found the resident on the floor. Left shoulder was noted to have redness but no swelling. Bruising was noted to right arm. B. Record review of the Situation, Background, Assessment, Recommendations (SBAR) Communication Form and progress note dated 03/07/15 indicated resident was found on floor and this has happened before. The resident does have a history of falls. On 02/16/15 resident was found on right side on floor mat next to her bed. Assessment indicated slight redness to right upper forehead and right deltoid (shoulder muscle) area. C. Review of care plan on 03/23/15 indicated that Bolster Mattress (a foam pressure-reducing scoop mattress) or wedges (triangular shaped foam pillow) for positioning are to be used while the resident is in bed. D. On 03/23/15 at 2:19 pm, during room observation there was no wedge identified or observed anywhere in the room. E. On 03/23/15 at 2:21 pm, during interview, when Registered Nurse (RN) #2, was asked what staff were using in place to prevent R#106 from falling, RN #2 stated pillows are placed at the resident's midback, but resident will pull pillows out from behind her. When RN #2 was asked about a wedge for R # 106 she indicated that she was not sure what a wedge was. F. On 03/23/15 at 2:48 pm, during interview Certified Nurse Aide (CNA) #2 was asked what is used to keep the resident from falling out of bed and for positioning. She stated that she tries to position resident on her back or on the left side facing the wall. CNA #2 indicated she puts a pillow behind the resident's back and behind the resident's knees, but the resident is pulling them out from behind her and is falling to the floor. CNA #2 further stated that the resident is rolling out of bed when she is on the right side and falling on the floor. She was asked if she has used a wedge to position the resident in bed. CNA #2 indicated that she was not sure what a wedge (triangular shaped foam pillow) was and knew nothing about one being used.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the physician provided clinical rationale and adequate monitoring of 3 Antibiotic medications (Doxyclcline [MEDICATION NAME], and [MEDICATION NAME]) for 1 (R #30) of 5 (R #'s 13, 30, 51, 100 and 137) residents reviewed for unnecessary medications. This deficient practice has the potential to negatively impact the resident's well-being through adverse medication consequences. The findings are: A. Record review of all Physician's Progress notes indicated that there was no progress note documentation related to the use of antibiotics, urinary tract infection, or wound infection. B. Record review of laboratory results for R #30 for a groin wound culture dated 02/16/15 showed growth of: a. Proteus Mirabilis (a bacteria that causes infection) which was susceptible to antibiotics [MEDICATION NAME]/[MEDICATION NAME] and resistant to [MEDICATION NAME]. b. [MEDICATION NAME] Faecalis (a bacteria that causes infection) susceptible to antibiotics [MEDICATION NAME] ([MEDICATION NAME]); [MEDICATION NAME]/Tazobactam and [MEDICATION NAME] and resistant to [MEDICATION NAME]. C. No laboratory results were found in R #30's medical record which indicated the presence of a urinary tract infection [MEDICAL CONDITION]. Findings related to [MEDICATION NAME]: D. Record review of R #30's medical record found an order dated 02/04/15 stating [MEDICATION NAME] Capsule 100 mg (milligrams) by mouth two times a day for probable bacterial infection. No stop date was included in the order. E. Record review of R #30's Medication Administration Records (MARs) for 02/01/15 to 03/18/15 indicated that [MEDICATION NAME] 200 mg had been given 2 times a day starting on 02/05/15 at 8:00 pm, and continued to be administered 2 times a day through 03/18/15. F. On 03/19/15 at 4:13 pm, during interview Registered Nurse (RN) #3 stated that per the physician, the Doxycline is being given for [MEDICATION NAME] for wound, and that the resident wants to keep this medication because she thinks it is helping her. Findings related to [MEDICATION NAME]: G. Record review of R #30's medical record found an order dated 02/12/15 stating [MEDICATION NAME] HCl Tablet 500 mg 1 tablet by mouth two times a day for

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) infection for 10 days. No notation of the location of an infection was included in the order. H. Record review of R #30's medical record found an order dated 02/24/15 stating [MEDICATION NAME] HCl 500 mg two times a day to cover [MEDICATION NAME] (a bacteria that causes infection) for 14 days. I. Record review of R #30's MAR for February 2015 showed that [MEDICATION NAME] HCl 500 mg was given twice daily, beginning 02/12/15 and ending 02/22/15. It was then restarted on 02/25/15 and continued through 03/10/15. Findings related to [MEDICATION NAME] (Keflex) J. Record review of R #30's physician orders [REDACTED]. No indication for the antibiotic was noted. K. Record review of a physician's orders [REDACTED]. L. Record review of R #30's MAR found that Keflex 500 mg was administered by mouth four times daily for UTI for 10 days, beginning on 02/20/15 and continuing through 03/02/15.
F 0362 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Hire sufficient dietary support personnel.** Based on observation and record review, the facility failed to have sufficient support personal during meal times to assist 11 (R #'s 4, 14, 21, 22, 29, 49, 57, 79, 87, 85 and 98) of 11 (R #'s 4, 14, 21, 22, 29, 49, 57, 79, 87, 85 and 98) residents observed during dining observation. These residents had to wait 30 minutes before being able to eat. This deficient practice resulted in residents having to eat cold food or no food at all. The findings are: Findings for R (#'s 4, 14, 21, 22, 29, 49, 57, 79, 81, 85 and 98) A. On 03/16/15 at 6:00 pm, during dinner observation in dining room 3, it was observed that the residents that are total care had to wait 30 minutes (starting at 5:30 pm) until all trays were passed out to the other residents (finished at 6:00 pm). During service the (staff) uncovered the food and left it in front of those residents who are unable to assist themselves. Residents that need to be prompted/cued to eat had to wait 30 minutes until all trays were passed out to the other residents. The (staff) uncovered the food and left it in front of the residents. B. Review of a seating chart for dining room #3 (not dated) indicated that R #'s 4, 14, 21, 49, 79, 81, 85 and 98 need assistance to eat due to being totally dependent on staff to eat, the residents are not able to use their arms/hands due to contractors. Residents # 22, 29 and 57 need to be prompted/cued to eat due to memory affected by dementia and are dependent on staff for prompting. C. On 03/25/15 at 10:01 am, during interview the Restorative Aide was asked if she would point out the residents on the dining chart for dinning room 3 who were total care and needed cueing to eat. She doubled checked the chart and stated They (Resident's #'s 4, 14, 21, 22, 29, 49. 57, 79 81, 85 and 98) are all total assist, but there are a few that need prompting so they are seated at tables with the residents that staff can assist and cue.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation, interview and record review the facility failed ensure medications were appropriately stored by: 1) Medication carts were not locked on Units A and B. 2) Not preventing potential contamination of medication as well as medical supplies by storing appliances and food in one of two medication storage rooms on Unit C. This deficient practice had the potential to affect 53 residents residing on Unit A and Unit B, and 33 residents residing on Unit C as indicated on the resident Census Report List provided by the Administrator on 03/16/15. This deficient practice also had the potential for residents to have adverse drug reactions and possible ingestion of harmful topical ointments and potential contamination of medications or medical supplies due to inappropriate items stored in medication room. The findings are: Findings for unlocked medication carts for residents on Unit A and Unit B: A. On 03/16/15 at 2:40 pm, during initial tour on Unit A and Unit B, a treatment cart containing topical ointments and cleaning solutions was found to be unlocked and unattended. B. On 03/19/15 at 8:58 am, observation of R #90 revealed the resident to be seated in her wheelchair in front of the nurses station on Unit A and Unit B repeatedly pulling on the drawers to the medication cart. C. On 03/19/15 at 11:56 am, during observation of Unit A and B, a medication cart was observed to be unlocked and unattended. There were no staff in close proximity to the unlocked medication cart. D. On 03/19/15 at 12:07 pm, during interview Registered Nurse (RN) #1 confirmed that the medication cart should be locked at all times, stating I usually do (lock it), I don't know what happened. E. On 03/19/15 at 3:11 pm, during interview with the Director of Nursing Services (DNS), when asked what the expectation for the medication cart is, she stated, The expectation is they (staff) keep them locked at all times. F. Record review of the Medication Administration policy revised on 01/02/14, indicated under practice standards, Maintain security of cart and keys at all times. Findings for Medication Storage rooms located on Unit C: G. On 03/24/15 at 2:09 pm, while entering the medication storage room on Unit C, RN #2 ran into the medication room and grabbed a Styrofoam container off the counter and stated Please don't eat my lunch. H. On 03/24/15 at 2:19 pm, during during observation of the Unit C Medication Storage Room, an automatic coffee pot and a coffee mug next to the sink and a microwave plugged in and functional, placed on top of the medication refrigerator. Also noted was three packets of coffee and a container of an unlabeled/dated coffee mate creamer located in the resident refreshment refrigerator. I. On 03/24/15 at 2:28 pm, during interview when questioned regarding the coffee pot, microwave and the packets of coffee, RN #3 stated that she had not noticed the microwave in the medication room and then said, These things should not be in here. When asked about the coffee creamer, RN #3 stated It may belong to a resident but I very much doubt it. I am not happy about this. J. Record review of the Pharmacy Services Policies and Procedures Policy dated 05/16/11 indicated under purpose and process, To prevent contamination and Food is not stored in the refrigerator, freezer, or general storage areas where drugs and biological's are stored.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that accurate and complete medical records were maintained for 4 (R #'s 4, R #102, R #106, R #123) of 4 (R #'s 4, R #102, R #106, R #123) residents reviewed for activites, range of motion, and feeding tubes as evidenced by: 1. One-to-One Activity Participation logs, for residents incapable of participating in group activities, were incomplete, missing, or inaccurate for R #4, R #102, R #106 and R #123. 2. Range of Motion services were not being documented on the Restorative Nursing Record for R # 123. 3. Staff failing to transfer specific interventions regarding treatment and assessment of the feeding tube insertion site to the Treatment and Rehabilitation Form (TAR) for R #106. This deficient practice has the potential to lead to inaccurate assessments of residents' progress and faulty identification of residents' needs, negatively impacting resident health, safety and psychosocial well-being. The findings are: Findings related to Activities: A. Record review of the Recreation Quarterly Progress Note dated 02/12/15 found the statement, Participates in individual intervention program? Yes. 3x (three times) weekly 1:1 room visits. Participation level is noted to be passive. B. Record review of the One-to-One Activity Participation logs provided by the Activities Aide on 03/20/15 at 10:25 am, after being requested on 03/20/15 at 9:20 am, revealed: 1. On the logs for the month of December 2014 and January 2015, participation was documented on every Tuesday, Thursday and Saturday. Rather than initialing each entry as it was completed however, the Activities Aide initialed the first entry only, and then drew a line to indicate her initials for the remainder of the month. 2. On the log for the month of February 2015, the activities aide had used the numeral 1 to indicate February. This error occurred on each entry throughout the month, and in each case was corrected with a number 2 written over the number 1. The activity aide's initials were again written on the top line only, and then drew a line to indicate that she had performed the activity on each Tuesday, Thursday and Saturday for the remaider of the month. C. Record review of the Employee Time Cards for the Activities Aide, indicated that she had not worked on 9 of the dates on which the One-to-One Activities Participation Logs indicated that she had performed activities with R #4 (12/20/14, 12/25/14, 12/27/14, 01/01/15, 01/03/15, 01/06/15, 01/08/15, 02/10/15 and 02/17/15). Notations on the Time Cards variously list reasons for absence such as Holiday, Bonus Holiday, and Hourly Sick, for some dates, while others do not give reasons but do not show times clocked in and out. D. On 03/24/15 at 9:05 am, during interview with the Vice President of Operations, he verified that days on Employee Time Cards which do not contain clock in and out times are days on which an employee did not work. He stated that the Activities Aide was not presently in the building or available for an interview due to having been called out-of-state on an emergency. E. On 03/25/15 at 1:10 pm, during interview with the Activities Director, she stated that the presence of the Activities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325085	A. BUILDING _____ B. WING _____	03/25/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN JUAN CENTER	806 WEST MAPLE STREET FARMINGTON, NM 87401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) Aide's initials on the One-to-One Activities Participation Logs indicated that the Activities Aide personally performed the listed activity. When advised that the Activities Aide had not worked on 9 days for which she had made entries on the logs, the Activities Director was unable to explain the discrepancy. F. On 03/25/15 at 1:10 pm, the Activities Director was asked to produce One-to-One Activity Participation Logs for R #4 for 3 earlier months (September, October and November 2014), and was accompanied to the Activities area and the Medical Records office when she attempted to retrieve them. On 03/25/15 at 1:35 pm, she stated that she was unable to locate One-to-One Activities Participation Logs for the three requested months. G. Record review of the care plans for R #102 and R #106 indicated that they were to receive 1:1 activities three times weekly. H. On 03/24/15 at 1:10 pm, during interview with the Activities Director, she was asked to provide One-to-One Participation Logs for both residents for the first three months of 2015. She produced activity logs for the months of February and March 2015. I. On 03/24/15 at 1:35 pm, during follow-up interview with the Activities Director, she stated that she was unable to locate a One-to-One Activities Participation Log for the month of January 2015 for either resident. J. Record review of Care Plan dated 12/29/14, indicated Resident exhibits or is at risk for limited meaningful engagement related to cognitive loss/loss of function, adjustment to placement, loss of motivation and initiation. Interventions for R #123 include: establish a relationship with resident via one to one interventions and provide one to one 3 times per week. K. Record review of the One-to-One Activity Participation Log dated 02/02/15 through 02/27/15, indicated three one-to-one visits that did not occur when scheduled. The entries are left blank. Rather than initialing each entry as it was completed however, the Activities Aide initialed the first entry only, and then drew a line to indicate her initials for the remainder of the month. L. Record review of the One-to-One Activity Participation Log dated 03/02/15 through 03/30/15, indicated on two occasions one-to-one visits did not occur when scheduled. The entries are left blank. Again, the Activities Aide initialed the first entry only, and then drew a line to indicate her initials. M. On 03/19/15 at 9:38 am, during interview when the Activities Aide was asked about the entries on the One-to-One Activity Participation Log, the Activities Aide stated, It was marked wrong. The check marks are not supposed to be there. The Activities Aide confirmed the boxes for 02/02/15 and 03/02/15 should not be checked, stating They shouldn't be there. N. On 03/19/15 at 3:26 pm, during interview when the Activities Director was asked if she documents her room visits on the One-to-One Participation Log she stated, It should be there. When the Activities Director was given the One-to-One Participation Log she stated, I know it should be, (referring to documenting when she does a room visit) but I haven't. I haven't documented on there (One-to-One Participation Log) which I know I should. The Activities Director confirmed that the documentation represents R #123 is only getting one-to-one visits once a week for both February 2015 and March 2015. Findings related to ROM for R #123: O. Record review of Restorative Nursing Training Program dated 02/18/15, indicated there was no documentation showing R #123 received Restorative range of motion (ROM) services for 03/01/15 through 03/31/15 for both morning shift from 7 am to 3 pm and the evening shift from 3 pm to 11 pm. The # (number) of minutes of restorative activity, initials of person assisting patient, and patient performance code are left blank for the month of March 2015 and for both morning and evening shifts. P. On 03/23/15 at 1:51 pm, during interview Certified Nursing Assistant (CNA) #3 was asked where ROM exercises are documented, she stated, In the ADL (activities of daily living) books. Our restorative sheets are in there. CNA #3 confirmed the Restorative Nursing Record located in the ADL book was not filled out for R #123, stating It should be, but it's not. I don't know if they (staff) forgot to write it in or what. CNA #3 was asked if morning shift and evening shift are documenting on the form, CNA #3 stated No. Q. On 03/23/15 at 2:41 pm, during interview CNA #2 confirmed ROM exercises are documented in the ADL books. CNA #2 stated I know there are papers in the ADL charts, but that is for restorative to use. R. On 03/24/15 at 10:53 am, during interview with the Restorative Aide when asked if she documents when she does ROM exercises, Restorative Aide stated Yes. They should be. When the Restorative Aide was showed the Restorative Nursing Record, she confirmed there was no documentation for the morning or evening shift, indicating R #123 was receiving range of motion services. The Restorative Aide further confirmed the Restorative Nursing Record is where she is supposed to chart, but that she was not documenting for R #123. The findings for R #106 regarding feeding tube care are: S. On 03/23/15 Record review of the Care plan dated 12/13/14 regarding R #106's feeding tube/ G tube indicated, Assess skin around G tub site, skin care and dressing as ordered. T. On 03/23/15 at 3:56 pm, during interview Registered Nurse (RN #3) stated The nurses do a daily assessment of the peg tube site and I am called to look at the site if there is any problems with it. U. On 03/23/15 Record review of R #106's Treatment Administration Record (TAR) dated March 2015 had no notation for G tube site skin assessment, treatment or dressing changes. V. On 03/23/15 at 4:15 pm, during interview RN #2 confirmed and stated that, Skin check or dressing change at peg tube site for R #106 was not included in the residents (R #106) TAR. W. On 03/24/15 at 9:54 am, during interview RN #3 stated, When asked where this assessment would be documented RN #3 stated The assessment would be noted in the TAR. When asked as the clinical educator what her expectations were RN #3 stated, If it is noted on the Care Plan I would expect to see it on the TAR. X. On 03/24/15 record review of R #106's Nursing Assessment/skin assessment (not dated) had no documentation or notation indicating a G tube was present. Y. On 03/24/15 at 2:51 pm, during interview RN #3 was asked why R #106, who was admitted to the facility on [DATE], had no documentation or notations indicating any assessment, cleansing or dressing changes of R #106's G tube site since her admitted , RN #3 stated she was not sure how this was overlooked and apologized for the lack of documentation.