STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. BUILDING _____ B. WING _____	06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINE COUNTRY CARE CENTER	321 WEST TURNER ROAD LODI, CA 95240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 40214 HFEN, 36738 HFEN, 32525 The facility census was 84. The sample size was 20. One (1) facility reported incident #CA00641740 was investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00641740.	F 000	7/23/19 POC Accepted RSchmitt HFES	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		7/19/19

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

Electronically Signed | 07/12/2019

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dignity and respect were maintained for two of 20 sampled residents (Resident 60 and Resident 44) when: 1. Staff did not knock on the door before entering resident's room; and 2. Staff stood over the resident while assisting him to eat. These failures increased the potential to diminish residents' self-esteem and self-worth.	F 550	F 550 Resident Right/ Exercise of Rights CFR (s): 483.10 (a) (1)(2)(b)(1)(2) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. After HFEN informed the DON of knocking incident DON immediately designated Administrative Staff to monitor and observe staff compliance.	

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F 550	Continued From page 2 Findings: 1. According to the 'Admission Record', the facility admitted Resident 60 in early 2015 with diagnoses which included Parkinson's disease (a disorder of the brain that causes stiffness and shaking) and osteoarthritis (bone joint disease). A review of the latest Minimum Data Set (MDS, an assessment tool) dated 5/12/19, indicated Resident 60 scored 1 out of 15 on a Brief Interview for Mental Status (BIMS, an assessment for cognitive function), indicating severe memory deficit. During an observation on 6/19/19 at 2:30 p.m., Resident 60 was sleeping in her bed. Certified Nurse Assistant (CNA) 1 entered Resident 60's room without knocking on the door and did not introduce herself when she entered the room. During an interview on 6/20/19 at 1:30 p.m., CNA 1 stated that knocking on the door and introducing herself skipped her mind. CNA 1 further stated that she should have knocked on the door before entering and introduced herself to the resident. The facility policy titled "Quality of Life - Dignity" revised August 2009, indicated "Residents shall be treated with dignity and respect at all times...Staff will knock and request permission before entering residents' rooms." During an interview on 6/20/19 at 2 p.m., the Administrator (ADM) stated that it was expected that all staff should knock on resident's door and introduce themselves before entering the resident's rooms. The ADM acknowledged that	F 550	After HFEN informed the DON of assisted dining incident DON immediately designated Administrative Staff for subsequent days following the incident. Resident 44 was observed during meal time to have been assisted with CNA sitting down at eye level. Staff did not observe any emotional distress from Resident during observation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Random inspection and observation were done by DSD and/or designee during meal time and during ADL care if staff is knocking on the door and not standing over while feeding the resident. There were no other residents identified. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; In-services will be conducted by the DSD or designee and upon hired by new employee regarding resident's rights and dignity with emphasis on knocking on the door and not standing over the residents while feeding. How the facility plan to monitor its performance to ensure the solutions are sustained; DSD or designee will do a random	

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F 550	Continued From page 3 the CNA 1 should have knocked on the door and introduced herself before entering Resident 60's room. 2. According to the 'Admission Record', the facility admitted Resident 44 in mid-2017 with diagnoses which included dementia (memory loss) and hearing loss. A review of the latest MDS dated 4/21/19, indicated Resident 44 scored 99 on BIMS, indicating Resident 44 was unable to complete interview. During an observation and concurrent interview on 6/19/19 at 2:30 p.m., Resident 44 was seated in a chair by the door. CNA 2 was observed standing over Resident 44 while helping the resident eat ice cream for snacks. CNA 2 stated that she should have been sitting at the resident's eye level while assisting Resident 44 to eat. During an interview on 6/20/19 at 10:15 a.m., Licensed Nurse (LN) 1 stated that CNA 2 should have been sitting at the resident's eye level when she helped feed Resident 44. "The facility policy titled "Quality of Life - Dignity" revised August 2009, indicated "Each resident shall be cared for in a manner that promises and enhances quality of life, dignity, respect and individuality." During an interview on 6/20/19 at 10:35 a.m., the Director of Nursing (DON) stated that the staff should have been sitting at the resident's eye level while she helped Resident 44. DON acknowledged it was a dignity issue when CNA 1 was not seated at eye level when helping resident	F 550	inspection and observation 2 different meal times in a week x 3 months and then quarterly. The results of the review will be reported to the QA Committee quarterly by the DSD or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	

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F 550	Continued From page 4 44 to eat.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to	F 578		7/21/19

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F 578	Continued From page 5 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have a POLST (Physician Orders for Life-Sustaining Treatment-a document that records resident's treatment wishes) record in one of 20 sampled resident's chart (Resident 76). This failure had the potential for the resident to receive care that was contradictory to her health care treatment wishes. Findings: According to the 'Resident Face Sheet', Resident 76 was admitted early 2018 with diagnoses that included dementia and age related osteoporosis (A condition in which bones become weak and brittle.). The assessment dated 6/2/19 indicated she was severely mentally impaired and required extensive assistance for all activities of daily living. During an observation of Resident 76's clinical chart and concurrent interview with Licensed Nurse (LN 3) on 6/20/19 at 11:06 a.m., LN 3 confirmed there was no documented evidence that the resident had a POLST filled out to indicate her code status (whether a patient wishes treatment to prolong their life). During a review of the clinical record for Resident 76 the "Advanced Healthcare Directive" dated	F 578	F 578 Request/Refuse/Discontinue Treatment;Formulate Adv Dir CFR (s): 483.10 (c) (6)(8)(g)(12)(i)- (v) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice: Resident s POLST was updated and signed by the MD and resident s rep. and it matched the Advanced Directive. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Medical Records Director and/or designees will do an audit of all the POLSTs to ensure that it matches the Advanced Directive if there are any on all existing residents based on the quarterly MDS schedule. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; The facility Medical Records Director and/or designee will complete an audit of	

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F 578	Continued From page 6 1/30/18, indicated that, "In the event that your heart and breathing stop, Resident's wishes were: I want CPR attempted (Cardiopulmonary Resuscitation). During a review of the clinical record for Resident 76 the "Physician Orders" print dated 5/28/19, indicated that the Code Status was DNR (Do Not Resuscitate) in contradiction to the Advanced Directive. During a review of the clinical record for Resident 76 the "Resident Face Sheet" indicated that "There are no Advanced Directives Selected for this resident." (There was an Advanced Directive). The Face Sheet also indicated to "See POLST form in chart for code status. (There was no POLST in the chart). In an interview with the Director of Nurses (DON) on 6/20/19 at 11:12 a.m., she also confirmed there was no POLST in Resident 76's medical chart. The DON further stated that the resident names on the doors to their rooms are colored coded to indicate code status for the residents. She stated that if a resident's name is written in black they should be a full code and if the name is written in red they have a code status as DNR-do not resuscitate. During an observation on 6/20/19 at 11:15 a.m., of Resident 76's door way, her name sign was black which would have indicated she was a "Full Code". During an interview with LN 3 on 6/20/19 at 11:06 a.m., she stated she did not know what the code status was for Resident 76.	F 578	all residents' POLST form and compare it to the residents' Advanced Directive, when applicable, to ensure that these records match. This will be completed in the next 30 days (completion date: 07/21/19). During care conferences POLST and Advanced Directive if any will be reviewed during care conferences and will be updated as necessary. Social Services will in-service the members that attend the care conferences. How the facility plan to monitor its performance to ensure the solutions are sustained; The facility Social Service Director and/or designee will continue with follow up compliance audits during Admission/Re-admissions and based on the resident's quarterly MDS schedule to identify discrepancies. MRD and/or designee will do audits of the POLST and Advanced Directive based on the quarterly MDS schedule. The results of the review will be reported to the QA Committee quarterly by the MRD and/or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be	

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F 578	Continued From page 7 The facility was unable to produce a policy on Advanced Directives/POLST.	F 578	corrected immediately.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure personal hygiene was maintained for one of 20 sampled residents (Resident 45) when her fingernails were dirty and untrimmed. This failure had the potential to negatively impact Resident 45's psychosocial well-being as well as injuring resident's skin and promote infections. Findings: According to the 'Admission Record', the facility admitted Resident 45 in late 2018 with diagnoses which included tremor (uncontrollable shaking) and age-related osteoporosis (bone disease). A review of the most recent Minimum Data Set (MDS, an assessment tool), dated 4/21/19, indicated Resident 45 scored 11 out of 15 on a Brief Interview for Mental Status (BIMS, an assessment for memory that use scores from 1-15 with 15 designating no memory loss), indicating mild memory deficit. The MDS reflected she was totally dependent on others for assistance with ADLs (activities of daily living) and required 1-person assistance to provide	F 677	F 677 ADL Care Provided for Dependent Residents CFR(s):483.24 (a) (2) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. Resident's fingernails were trimmed during identification and it will be inspected and fingernails will be trimmed q weekly. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; DON and Nursing leaders did a facility wide inspection of all residents' fingernails and residents with long and dirty fingernails were trimmed and cleaned. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice	7/19/19

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F 677	Continued From page 8 personal hygiene. A review of Resident 45's ADL Care Plan dated 10/18/18, indicated that Resident 45 required extensive assistance for setting up equipment for hygiene/grooming. During an observation 6/18/19, at 4:35 p.m., Resident 45's was sitting in a chair, her fingernails were noted to be untrimmed about 1/4 centimeters in length from the fingertips, jagged, yellowish in color, dirty with black substance underneath the nail beds. During an interview on 6/18/19, at 4:48 p.m., LN 2 stated that Resident 45's fingernails were dirty and untrimmed. LN 2 further stated that CNAs should have cleaned and trimmed Resident 45's fingernails. The facility policy and procedure titled "Care of Fingernails/Toenails" revised October 2010, indicated "The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care includes daily cleaning and regular trimming...Proper nail care can aid in the prevention of skin problems...Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin." During an interview on 6/18/19, at 4:41 p.m., the DON stated that it is the CNAs job to check, clean and trim the residents' fingernails. The DON acknowledged that Resident 45's nails should have been cleaned and trimmed.	F 677	does not recur; DSD or designee in-serviced the LNs and CNAs regarding inspection, cleaning and trimming of fingernails for residents. In-service will be also included during orientation process. How the facility plan to monitor its performance to ensure the solutions are sustained; DSD or designee will do random inspection of fingernails q weekly x 3 months then quarterly. The results of the review will be reported to the QA Committee quarterly by the DSD or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		7/21/19

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F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventative interventions for pressure ulcers were implemented in a timely manner for 1 of 20 sampled residents (Resident 3) when: 1. A special mattress was not provided in a timely manner, and, 2. Wound dressing was not dated and the resident was not repositioned after wound care. These failures resulted in Resident 3 acquiring a potentially avoidable pressure ulcer to the coccyx (tail bone). Findings: According to the 'Resident Face Sheet' the facility admitted Resident 3 early this year with multiple diagnoses including status post right hip fracture surgical repair, anemia and lung disease. The Admission Assessment indicated Resident 3	F 686	F 686 Treatment/Services to Prevent/Heal Pressure Ulcer CFR(s):483.25 (b) (1) (i) (ii) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. Resident 3's pressure ulcer is healing and the wound did not progressed to a higher stage. Although wound dressing was not noted but dressing was changed as indicated on the TAR and air mattress is already in place. Resident 3's pressure ulcer risk and care plan interventions have been updated and revised to reflect resident's current preventive care needs. The DON and DSD will be providing in-servicing to all direct care staff and licensed nurses	

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F 686	Continued From page 10 required extensive assistance to move in bed, was always incontinent with bowel and bladder and had moderate cognitive impairment. The assessment indicated she had no pressure ulcers but was at risk for pressure ulcer development. 1. During the Initial Pool on 6/18/19 at 10 a.m., Resident 3 was observed sitting up in wheelchair in her room and reported she had a pressure ulcer to the buttocks. Resident 3's clinical record was reviewed as follows: A 'Pressure Ulcer Risk Assessment' dated 3/2/19 indicated she scored 11 (a total score of 8 or above represented HIGH RISK), "... The resident should be considered HIGH RISK for skin breakdown [...and] prevention protocol should be initiated." A review of Resident 3's 'Weight Record' indicated the admission weight on 2/26/19 was 151.4 pounds and 151.4 pounds on 3/3/19. On 3/10/19, the weight was documented as 132.5 pounds and a weight loss of 18.9 pounds was documented. This represented a significant weight loss of 18.9 pounds in 7 days and a 14.2% weight loss. A review of Resident 3's 'Tracking Form' for 3/2019 indicated her meal intake for the month was poor (25-49% meal eaten) or refused (0-24% meal eaten). A 'Short Term Skin Care Plan' dated 3/21/19 indicated Resident 3 developed a stage 2 coccyx pressure ulcer that was documented on the pressure ulcer form dated 3/21/19 as measuring	F 686	regarding the facility's updated Skin Management policy and procedure. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; DON and Nursing leaders did a facility wide inspection of all residents who are high risk for pressure ulcers and air mattress is provided as needed. The facility has replaced the current pressure ulcer risk assessment tool with the BRADEN SCALE and instituted its use on 6/19/19. Based on this scale, the residents preventive interventions are formulated. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; The MDS Coordinator and/or designee have started to complete the re-assessment of all residents' risk and will have completed this process within the next 30 days (completion date: 07/21/19). Based on the result of the audits, residents who score Severe Risk and High Risk will be placed on turning schedules as part of their preventive management. DON and/or designee in-serviced the LNs regarding the new Pressure ulcer Assessment and dating of the dressing. In-service will be also included during orientation process.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11 1.6 by 0.8 by 0.2 centimeters (unit of measurements- length, width and depth respectively) and noted to contain slough (dead tissue). The 'Skin Risk Breakdown' care plan dated 2/26/19 indicated the resident's goal was, 'No skin breakdown...' The care plan indicated an air mattress overlay was not provided until 3/13/19, fifteen days later. A review of the facility's undated 'Wound and Skin Management' policy indicated in part, "A pressure ulcer is defined as any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers occur over bony prominence's and are graded or staged to classify the degree of tissue damage observed. Friction and shear are important factors to the development of pressure ulcers... Avoidable means that the resident developed a pressure ulcer and the facility did not ... implement interventions that are consistent with resident needs, resident goals..." A review of the facility's undated 'Wound And Skin Management' policy indicated, "It is the policy of this facility that any resident who enters the facility without pressure sores will have appropriate preventative measures taken to insure that the resident does not develop pressure ulcers..." The policy also contained a list of preventative measures including pressure reducing devices in bed and wheelchair for those identified to be at risk for skin breakdown. During an interview and concurrent clinical record review of Resident 3's record with the Director of Nursing (DON) on 6/21/19 at 11:53 a.m., she	F 686	How the facility plan to monitor its performance to ensure the solutions are sustained; MRD and/or designee will do a quarterly audit on the new Pressure Ulcer Assessment quarterly based on the MDS schedule. The results of the review will be reported to the QA Committee quarterly by the DON and/or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	

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F 686	Continued From page 12 stated the air mattress to the bed was initiated a week prior to the identification of the coccyx pressure ulcer, but should have been implemented on admission as she was assessed as high risk for skin breakdown. 2. On 6/21/19 at 11:35 a.m., Resident 3 had just been transferred to bed from the wheelchair after participating in activities and was lying on her back. Licensed Nurse 2 (LN 2) was observed as she assisted the resident to a side lying position and cleaned and changed the dressing to the coccyx pressure ulcer. LN 2 then assisted the resident back to the same back lying position after the procedure. LN 2 did not date the dressing she applied and she did not reposition Resident 3 to another position. During a concurrent interview with LN 2 on 6/21/19 at 11:35 a.m., she stated dressings should not be dated because the ink might get into the wound. LN 2 further stated she should have placed Resident 3 in a different position. A review of Resident 3's at risk for 'Skin Breakdown Care Plan' dated 2/26/19 indicated one of the interventions was to turn and/or reposition the resident every 2 hours. A review of the facility's 'Wound Care' policy dated 10/2010 indicated in part, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing... Mark tape with initials, time and date and apply to the dressing... [document] The position in which the resident was placed." During an interview with the DON on 6/21/19 at 11:53 a.m., she stated LN 2 should have dated	F 686		

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F 686	Continued From page 13 Resident 3's new dressing and placed her in another position in bed.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review for one of 20 sampled residents (Resident 76) the facility did not follow Restorative Nurse Assistant (RNA) goals for prevention/decline in range of motion and contractures (a deformity that limits range of motion) when Resident 76's hand roll was not applied. This had the potential to cause further decline of Resident 76's range of motion and permanent contractures of her hands and fingers. Findings:	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s):483.25 (c) (1)- (3) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. Resident's hand roll was put back during identification and will be monitored as indicated.	7/19/19

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F 688	Continued From page 14 According to the 'Resident Face Sheet', Resident 76 was admitted early 2018 with diagnoses that included dementia and age related osteoporosis (A condition in which bones become weak and brittle). The Minimum Data Assessment dated 6/2/19 indicated, she was severely mentally impaired and required extensive assistance for all activities of daily living. During an observation and concurrent interview with Certified Nursing Assistant (CNA 4) on 6/19/19 at 8:24 a.m., Resident 76 was sitting up in bed. Her right hand was curled up tightly. There was no visible hand roll. When asked if the resident should have a hand roll, CNA 4 stated that Resident 76 should have them on. CNA 4 confirmed there was no hand roll. CNA 4 continued to look in the bed and around the bed and was not able to locate the hand roll which indicated the resident did not take them off herself. During an observation and concurrent interview with CNA 3 on 6/20/19 at 1:40 p.m., Resident 76 was in her room sitting on her wheelchair playing with her doll. There was no hand roll seen. When asked, CNA 3 stated that the resident had a hand roll on this morning and stated it was velcroed on. Another CNA walked by and stated that she had used a wash cloth this morning to use as a hand roll and not the velcro one. Both CNAs confirmed that Resident 76 should have a hand roll in place at all times. Review of the clinical record for Resident 76, the Restorative Nursing Care Plan dated 3/5/18 indicated that Resident 76 was at risk for loss of mobility due to Osteoporosis. Goals were listed	F 688	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; There is no other resident that has a hand-roll order at this time. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; DSD or designee will in-service the LNs and CNAs regarding monitoring of the assistive devices q shift as indicated. Instructions on contracture prevention will be also included during orientation process. How the facility plan to monitor its performance to ensure the solutions are sustained; DSD or designee will do a random inspection and observation weekly x 3 months x then quarterly. The results of the review will be reported to the QA Committee quarterly by the DSD or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	

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F 688	Continued From page 15 as: will be able to tolerate right hand roll. Approach/Plan list included: passive range of motion and hand roll. Re- evaluation dates were 6/19 and 9/19. Review of the clinical record for Resident 76, the Recommendations for Restorative Nursing dated 5/22/19 indicated under "Special Instructions, Keep hand roll in right hand all times.." Review of the clinical record for Resident 76, the "Weekly Summary" dated 6/15/19, indicated "resident works with RNA on passive range of motion and hand roll". The facility policy and procedure titled "Restorative Nursing Services" dated July 2017 indicated, "Restorative goals and objectives are individualized and resident-centered, and are outlined in the individual resident's plan of care"...	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards for two residents (Resident 30 and Resident 56) of 20 sampled residents when:	F 689	F 689 Free of Accident Hazards/Supervision/Devices CFR(s):483.25 (d) (1) (2)	7/21/19

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F 689	Continued From page 16 1. Resident 30 fell forward out of her wheelchair when she tried to propel herself over the raised threshold of her room; and, 2. Resident 56 scraped her hand on a door jam when Certified Nursing Assistant (CNA) struggled to pull her in a shower chair over a raised threshold. This failure caused a fall and injury for two residents and had the potential to cause falls and injury for all residents of the facility. Findings: 1. According to the "Resident Face Sheet", Resident 30 was admitted in March of 2019 with diagnoses including Parkinson's disease (a disorder of the brain that causes stiffness and shaking). During interviews with Residents 2, 37, and 54 on 6/19/19 at 10:15 a.m., during the Resident Council Meeting, Resident 54 stated that she had mentioned to the Maintenance Supervisor (MS) that the thresholds [at the entrance to resident rooms] are too high. She stated that it was a safety concern. Resident 2 and 37 stated that going over the thresholds jar you and you can get stuck. During multiple observations on 6/19/19 starting at 10:30 a.m., all resident rooms were noted to have metal door thresholds that were raised between the resident rooms and the hallways. The shower rooms also had the raised metal thresholds.	F 689	How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. Resident 30's room raised threshold was fixed by a licensed contractor who leveled the threshold on 06/20/19. Wheelchair for the resident was also replaced that she can easily propel. The facility administrator and the maintenance director re-assessed the shower room size and ordered two narrower shower room chairs on 06/20/19 that are more appropriately sized for the two shower doors. The facility assessed all residents on 06/20/19 that can independently move in and out of their rooms for any difficulties with their room thresholds and no further residents were identified as having been affected. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the facility, except the ones who reside in the locked unit, have the potential to be affected. The doorways of the rooms in the locked unit do not have raised thresholds. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur;	

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F 689	Continued From page 17 During an interview with Resident 30 on 6/19/19 at 11:08 a.m., she stated that on Sunday [6/16/18] she was in her wheelchair and wanted to leave her room. Resident 30 added that she was having difficulty going over the threshold in her room and fell forward out of her chair and hit her face. During and interview with CNA 6 on 6/19/19 at 11:10 a.m., CNA 6 stated that it is hard to push the wheelchairs over the thresholds and that the residents "feel it" when you go over the bump. During a record review of Resident 30's clinical record, the document titled "IDT Progress Notes" (Interdisciplinary team notes) dated 6/17/19, indicated that, "[Resident 30] had a fall on 6/16/19 at 8:15 p.m., from her wheelchair while attempting to cross the threshold from her room to the hallway". During a record review of Resident 30's clinical record, the document titled "Post Fall Evaluation" dated 6/17/19, indicated under the Description of Fall: "Called to hallway by dietary staff, CNA by patient [Resident 30] at this time. Patient noted to be laying in hallway on her left side. Patient's wheelchair in the doorway. CNA stated that she saw the patient trying to come out of room, front wheels hit the threshold and patient fell out of wheelchair. States she witnessed patient hit her head..." 2. According to the "Resident Face Sheet", Resident 56 was admitted in October of 2018 with diagnoses including dementia. During an observation and interview with Resident 56 on 6/19/19 at 11:35 a.m., she stated she hit her hand on the door jam of a doorway	F 689	The facility will schedule a facility wide repair of thresholds with the plan to complete this project by 09/21/19. The facility is currently in the process of reviewing bids. All reported accidents/incidents will be reviewed by the IDT for root cause and rule out anything related to the thresholds. DSD and/or designee will in-service the LNs and CNAs regarding how to properly propel residents with raised floor threshold. In-service will be also included during orientation process. How the facility plan to monitor its performance to ensure the solutions are sustained; DSD and/or designee will do a random inspection and observation weekly x 3 months and then quarterly. The results of the review will be reported to the QA Committee quarterly by the DSD and/or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	

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F 689	Continued From page 18 when a CNA was pulling her out of the shower room in a shower chair. Resident 56 stated, "The CNA couldn't pull me out", my hands were on the arm rest and when she struggled to get me over the threshold my hand scraped the door jam. Observation of the resident's left hand showed a 4 x 4 gauze over the wound. The resident stated her fingers hurt and are hard to move but she could move them. "I took an aspirin, this just happened on Monday, day before yesterday [6/17/19]". During an interview on 6/19/19 at 11:50 a.m., CNA 4 stated that the shower chairs we use are hard to pull over the thresholds of the resident rooms and the shower room. During a record review of Resident 56's clinical record, the document titled "Nurses Notes" dated 6/17/19 indicated, "Resident noted to have 2 skin tears to top of left hand, CNA stated it happened while they were leaving shower room resident bumped hand on the door..." During an interview with CNA 2 on 6/19/19 at 1:32 p.m., CNA 2 stated she was pulling Resident 56 out of the shower and had to use a big shower chair and that it was hard to get the chair over the threshold. CNA 2 further stated that was how the resident's hand got scratched. "The thresholds are too high and very hard to get the shower chairs over them". During an observation and concurrent interview on 6/20/19 at 9:40 a.m., two CNAs were observed assisting a resident into the shower room. The resident was sitting on a shower chair and when they got to the threshold of the shower room the chair got stuck. The two CNA's pulled	F 689		

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F 689	Continued From page 19 the chair back into the hall then quickly pushed and pulled it and the resident over the threshold. CNA 2 stated that , "This is how Resident 56 got her hand hurt. You can see how hard it is for us to get in that [shower] room, the door is small and the shower chair is big and then the threshold is hard to get over". CNA 3 stated that it was difficult to maneuver into the shower room with the high threshold and narrow door. The facility policy and procedure titled "Accidents and Incidents-Investigating and Reporting" dated July 2017 indicated, " ...Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities".	F 689		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the	F 801		7/21/19

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F 801	Continued From page 20 United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national	F 801		

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F 801	Continued From page 21 certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview, personnel file and policy review, the facility failed to ensure a qualified Dietary Manager was hired in the absence of a full-time Registered Dietician (RD) for a census of 84. This failure had the potential for the resident's nutritional needs not to be met. Findings: During the Initial Kitchen Tour accompanied by a staff who introduced herself as the Assistant Dietary Supervisor (ADS) on 6/18/19 at 8:50 a.m., she stated that she was appointed to the position of a Dietary Manager recently on condition she was going to complete the education requirements for the position, which she had not. The ADS stated she had notified the outgoing facility Administrator that she did not wish to go back to school. The ADS stated the facility's dietician only worked twice per week. An interview conducted with the Consultant	F 801	F 801 Qualified Dietary Staff CFR(s):483.60 (a) (1) (2) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. All residents in the facility have the potential to be affected. Beginning 7/1/19, the RD hours have been increased to 32 hours per week while the facility is actively hiring a CDM. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents in the facility have the potential to be affected. Beginning 7/1/19, the RD hours have been increased to 32 hours per week while the facility is actively hiring a CDM.	

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F 801	Continued From page 22 Dietary Manager (CDM) on 6/19/19 at 10:05 a.m., she stated she had come in that day to help the facility. The CDM stated she worked in another facility but she was aware the facility did not have a qualified dietary manager and the dietician only worked 2 days per week. A review of the personnel files provided by the facility included the ADS file that had no documented evidence she met the qualification of a dietary manager in the absence of a full-time dietician as required by the regulations. The facility had provided 2 other personnel files for staff who had been hired last year but had quit. A review of the RD printed time for the period between 1/2019 and 5/2019 did not meet the minimum full-time requirement for the dietician (32 hours/week). During an interview conducted with the Administrator on 6/20/19 at 11:20 a.m., he stated the facility had no qualified dietary manager and the dietician only worked 2 days per week. The Administrator further stated the facility's plan was to increase the hours for the RD until they have a dietary manager in place. A review of the facility's 'Personnel Management' policy dated 1/1/2017 indicated the 'Director of Food & Nutrition Services' education requirements was, "... meets the requirements for [State name] Health and Safety code 1265.4; ... meets the requirements for [government agency's name] regulation...[has] Food Protection Manager Certificate."	F 801	What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; The facility has since hired a permanent full time CDM to start on 07/29/19. The facility will continue with the current 32 hours a week RD coverage for a period after new CDM starts full time permanent employment. How the facility plan to monitor its performance to ensure the solutions are sustained; Facility will continue to have 32 hours of RD coverage for a period after CDM starts full time permanent employment on 07/29/19. The RD will monitor the new CDM's performance and will recommend to the Administrator and the facility QA Committee for any concerns with compliance on a monthly basis for the next 3 months and quarterly thereafter. The results of the review will be reported to the QA Committee quarterly by the RD or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	

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F 838	Continued From page 23	F 838		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including	F 838		7/19/19

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F 838	Continued From page 24 but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT Is not met as evidenced by: Based on observation, interview and the Facility's Assessment document review, the facility failed to ensure the assessment included all elements as stipulated by the regulation. These failures had the potential for the facility not to include management of all the risks in their annual plan. Findings: A review of the 'Facility Assessment' document dated 4/1/19 reflected no documented evidence that an assessment of the Health Information and	F 838	F 838 Facility Assessment CFR(s):483.70 (e) (1)- (3) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. There is no resident affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what	

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F 838	Continued From page 25 Emergency Management were included. During an interview and concurrent Facility Assessment review with a Nurse Consultant (NC) on 6/20/19 at 10 a.m., she stated the assessment was inaccurate and the facility was working on it. An interview conducted on 6/20/19 at 11:20 a.m. with the Administrator, he stated the assessment lacked some of the essential components and handed in another copy. The Administrator was asked for the assessment policy guideline and he stated they were in the middle of acquiring the facility and a policy would be developed.	F 838	corrective action will be taken; There is no resident affected by the deficient practice. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur; Facility Assessment was reviewed and revised by the Administrator during the survey period. How the facility plan to monitor its performance to ensure the solutions are sustained; Facility Assessment will be reviewed and revised by the Administrator annually as required. The results of the review will be reported to the QA Committee quarterly by the Administrator or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F 908		7/19/19

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F 908	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen equipment was repaired in a timely manner for a census of 84. This failure had the potential to negatively impact the resident's food and services. Findings: During the Initial Kitchen Tour on 6/18/19 starting at 8:50 a.m., accompanied by the Assistant Dietary Supervisor (ADS), external air conditioning equipment was observed coming through the window with a long tubing directed towards the stove area. The Kitchen staff were observed as they navigated their way from one side of the kitchen to the other as the tubing was blocking their way. A concurrent interview conducted with the ADS on 6/18/19 at 8:50 a.m., she stated, the ventilation system located near the stoves was broken two weeks ago and the facility needed to replace the entire system. The ADS stated the external equipment was put in place to cool down the kitchen environment which had become unbearable. The ADS stated she was not sure when the ventilation system would be fixed. During a follow up kitchen observation on 6/19/19 starting from 9 a.m., the following equipment was observed broken or in need of repair: a. The steam hold handle was broken and the rubber seal was not closing properly; b. One of the 3 stove's oven door was broken and	F 908	F 908 Essential Equipment, Safe Operating Condition CFR(s):483.90 (d) (2) How Corrective actions will be accomplished for residents found to have been affected by the deficient practice. The ventilation system located near the stove was fixed by Licensed Contractor. The mentioned equipment as follows: a. Steam hold handle was fixed. b. The oven door that was broken was also fixed. Facility is in the process of purchasing a new oven. c. Cabinets was fixed and the wall papers were removed. d. Door of the cabinet located to the left of the kitchen door was fixed. e. Electrical Mixer was replaced. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; There is no resident affected by the deficient practice. What measures will be put into place or what systemic change will the facility put in place to ensure this deficient practice does not recur;	

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F 908	Continued From page 27 the oven was not operational; c. 5 cabinets located near the microwave and next to a food preparation area were noted with peeling of the wall paper; d. The door to a cabinet located to the left of the kitchen door was missing exposing water pitchers and, e. The electrical mixer was reported broken and the staff were observed struggling to use a manual mixer as they prepared the desert for the lunch meal. During a concurrent interview with the Kitchen Staff (KS) on 6/19/19 starting from 9 a.m., they stated the equipment was reported broken to the administration and they have been waiting for them to be repaired. The KS stated they worked with what was available and sometimes it took longer to prepare food. During an interview with the ADS on 6/18/19 at 10:30 a.m., she validated the above equipment was broken and stated, "I have been asking the prior owner to fix them." A review of the facility's 'Maintenance Service' policy dated 12/2009 indicated, "Maintenance service shall be provided to all areas of the building, grounds, and equipment." An interview conducted with the Administrator on 6/20/19 at 11:20 a.m., he stated he was aware of the multiple broken equipment in the kitchen and the facility was in the process of replacing or repairing them but they should have been replaced and/or repaired in a timely manner.	F 908	RD and Administrator will do monthly rounds on kitchen equipment and appliances monthly and as needed and ensuring that it is proper working condition. How the facility plan to monitor its performance to ensure the solutions are sustained; RD will continue monthly inspection of the kitchen equipment and appliances and report to the Administrator. The results of the inspection will be reported to the QA Committee quarterly by the RD or designee. The Administrator will re-evaluate the results of these audits for compliance on a quarterly basis through the Quality Assurance and Performance and Improvement Program. Any non-compliance identified will be corrected immediately.	
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii)	F 912		7/19/19

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F 912	Continued From page 28 §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident bedrooms measured at least 80 square feet per resident in 11 shared rooms. This failure had the potential to limit the personal belongings of each resident and compromise their ability to safely move freely in their rooms. Findings: During an observation on 6/18/19, at 9 a.m., the following rooms were observed to not meet the minimum space requirement for each resident: Room Occupancy Sq. Ft/ Res Req/Actual 2 2 Residents 66.6 160/142 3 2 Residents 71.5 160/143 4 2 Residents 72 160/144 8 3 Residents 67.7 240/203 41 3 Residents 75.6 240/227 43 3 Residents 74 240/223 44 2 Residents 72.5 160/145 45 3 Residents 74.6 240/224 46 2 Residents 75 160/150 47 3 Residents 76.6 240/230 48 2 Residents 72 160/144 During a continuing observation on 6/18/19, at 9:20 a.m., all rooms had adequate space for resident's beds, wheelchairs and bedside tables. Staff were able to move easily in and out of all rooms.	F 912	F 912 Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s):483.90 (e) (1)- (ii) Resident in rooms 2,3,4,8,41,43,44,45,46,47, and 48 are affected by rooms measuring less than 80 square feet per bed. To accommodate these residents reasonable amount of privacy as well as appropriate furnishings and storage areas will be maintained. Residents in these rooms will be monitored daily by the nursing staff to provide sufficient space for nursing staff to provide appropriate care. The social service designee will monitor rooms needing waivers monthly and report findings to the quality assurance committee. Room changes as necessary.	

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F 912	Continued From page 29 During an interview on 6/18/19, at 9:40 a.m., LN 2 stated there appeared to be adequate space for the three beds and three wheel chairs. LN 2 stated that the room was plenty big and she and the staff had no difficulties in moving around and providing care for the three residents in a room. During an interview on 6/18/19 at 10 a.m., Resident 18 stated that she doesn't have issues moving in the room and getting out with her wheelchair. During an interview on 6/19/19 at 9:30 a.m., LN 1 stated that she doesn't have any issues about moving the residents in the rooms in station 2. During an interview on 6/19/19 at 9:45 a.m., CNA 2 stated that she had no issues with moving around the room to provide care for the residents. During an observation and concurrent interview on 6/20/19 at 10 a.m., Resident 229 stated she had plenty of space for her therapy. During the Resident Council meeting interviews on 6/19/19, residents did not express dissatisfaction with the size of their rooms. During the survey starting 6/18/19 through 6/21/19, residents in the locked unit were observed as they went in and out of their rooms. Caregivers were also observed as they provided care for residents in their rooms. In a group interview conducted with a Licensed Nurse and two Certified Nursing Assistants on 6/19/19 at 11:28 a.m., they stated they had no issues providing care to the residents in their	F 912		

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F 912	Continued From page 30 rooms. Based on the findings during Re-certification survey, the Department recommends the continuation of the room size waiver for rooms 2, 3, 4, 44, 46 and 48 housing 2 residents each. The Department recommends continuation of the room size waiver for rooms 8, 41, 43, 45, and 47 housing 3 residents each.	F 912		