STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345511	A. BUILDING _____ B. WING _____	01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF STATESVILLE	2001 VANHAVEN DRIVE STATESVILLE, NC 28625

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		2/16/15

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

Electronically Signed | 02/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to thoroughly investigate an allegation of abuse by staff for 1 of 3 residents reviewed for abuse (Resident #109). The findings included: Resident #109 was admitted to the facility on 06/12/14 with diagnoses that included congestive heart failure, hypertension, presenile depression and chronic pain syndrome. A Minimum Data Set (MDS) assessment dated 07/10/14 indicated the resident was cognitively intact for daily decision making and had no memory impairment. The MDS also indicated the resident did not refuse care or have any behavioral symptoms such as being verbally or physically abusive towards staff. According to the MDS, Resident #109 required limited assistance of 1 staff with bed mobility, transfers and toilet use, was occasionally incontinent of bladder and always continent of bowel. A care plan dated 06/13/14 and updated 07/23/14 addressed Resident #109's need for limited assistance with toileting needs and included an intervention which specified "place urinal within reach." Review of the facility's abuse investigations revealed the facility received a report on 07/17/14 from a social worker at the local hospital stating that Resident #109 reported an incident had occurred about 3 nights prior to 07/17/14 when a nurse aide (NA) was mean to him and took his urinal and refused to bring him any water. According to documentation of the facility's investigation, the Director of Nursing (DON) met with the resident when he returned to the facility on 07/17/14 and Resident #109 made the	F 225	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the correctness of the conclusion stated on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under state and federal laws. F 225 This facility has a policy that prohibits the of hire individuals who have been found guilty of abusing, neglecting, or mistreating patients by a court of law; or who have had a finding entered into the state nurse/nurse aide registry concerning abuse, neglect, mistreatment of patients, or misappropriation of their property. The facility will report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse/nurse aide registry or licensing authority. The facility will report and investigate all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of patient property. Resident # 109 was discharged from the facility on August 18, 2014. For residents with the potential to be affected by the alleged deficient practice	

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F 225	Continued From page 2	F 225		

following statement: "about 3 nights ago the NA took my urinal and told me I could not have any water because I used the urinal too much. She took the urinal and was gone for over 45 minutes. When she finally came back she had the urinal and some water. She then told me I had to make 3 deposits in the urinal before calling her to empty the urinal. I told her I didn't feel comfortable doing that because I may spill the urine. I didn't want to make a mess." The documentation indicated Resident #109 stated he hadn't reported the incident to anyone at the facility because he had a different NA the next night.

According to the investigation documentation, the DON obtained a statement from NA #2, who was assigned to work with the resident on 07/14/14 on the night shift, and the NA denied the allegations. The DON also interviewed the nurse on duty on 07/14/14 on the night shift and she stated Resident #109 had not reported having his urinal taken or being denied water by NA #2.

Review of Resident #109's medical record revealed documentation by the social worker of a care plan meeting with the resident and his family that was held on 07/18/14. According to the note Resident #109 denied any concerns or problems with his care.

An interview with the DON on 01/15/15 at 4:17 PM about the investigation of Resident #109's allegation revealed she had not interviewed staff from any other shifts who worked around the time of the alleged incident. The DON stated she had asked the house supervisor if there had been any complaints about NA #2 and there hadn't been any other complaints from residents or staff. She stated she didn't interview any other residents

the following has been achieved:
The Director of Nursing is no longer affiliated with this facility. The Administrator, ADON, RN supervisor, and social worker were retrained by the Regional Nurse Consultant 1/26/2015. All other department managers were in-serviced by the Regional Nurse Consultant 01/26/2015: In-service included allegations requiring investigation: abuse, neglect, diversion, fraud, misappropriation of property, injuries of unknown origin. Investigation begins immediately following critical elements: who, what, when, where. Document all steps taken during investigation, statements from alleged victim, accused person, and other pertinent information related to the investigation. Statements of other residents and staff as indicated according to the allegation. Surmise the information collected, document action taken against the accused personnel, whether investigations were conducted by other state agency, or police department and outcome of the investigation. Submitting 24 hour report for allegation timely within the 1st 24 hours and follow up with the 5 day allegation form.

Direct care staff were re-in-serviced for reporting and investigating allegations of abuse neglect by the Regional nurse consultant. In-service included: interactions with residents being kind, listening to the resident and being sensitive to needs, report all allegations of abuse/neglect immediately to the charge

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F 225	Continued From page 3 who received care from NA #2 but thought the social worker had interviewed 5 other residents An interview with the Administrator on 01/16/15 at 9:59 AM revealed the social worker did not interview any other residents about the care they received from NA #2. A second interview with the Administrator on 01/16/15 at 11:52 AM about his expectation for interviewing other residents, who had been provided care by an accused staff member, revealed whether or not other residents were interviewed depended on the situation. He offered no explanation for other residents not being interviewed following the allegation by Resident #109.	F 225	nurse or supervisor, informing the DON and Administrator for all allegations so they may be reported timely with the initial report being within 1st 24 hours. The following systematic changes have been implemented to prevent recurrence. Retraining of staff. Development of QA tool to track all allegations with the following information: brief description of the allegation & date received, date 24 hour form faxed with receipt (to ensure allegation reported within 24 hours), 5 day form completed and fax date with receipt, summary of investigation completed, written statements from others, comments and date and staff name completing the audit. The administrator reviews and transcribes all allegations of abuse neglect on the audit tool upon receipt of the allegation. This new system will become a permanent part of the process for monitoring completeness for investigation and follow up to ensure a thorough investigation has been done. A quality assurance program was implemented under the supervision of the administrator to monitor all allegations of abuse/neglect. The Administrator is responsible to audit all allegations of abuse/neglect 5 days a week as they are reported so information may be monitored for compliance to ensure thoroughness of information for the investigation including resident	

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F 225	Continued From page 4	F 225	involved, other resident interviews, staff interviews all shifts as indicated. Any concerns identified will be corrected immediately. The administrator will document quality concerns with identified areas for deficiency to the quality assurance committee quarterly for further corrective action.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow their abuse policy for investigating an allegation of abuse by staff for 1 of 3 residents reviewed for abuse (Resident #109). The findings included: A document titled "Abuse/Neglect Policy" revised 01/17/14 read in part: "When an incident or suspected incident of patient abuse or neglect is reported, the Administrator or designee investigates the incident. Any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of patient's property must be reported to the immediate supervisor (Charge nurse or Nurse Supervisor). The nurse will notify the Director of Nursing and the Administrator, or designee in the	F 226	F 226 It is the policy of this facility that each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion, mistreatment, neglect and misappropriation of property. The facility has developed policies that focus 0n seven components: screening, training, prevention, investigation, protection and reporting/response. Resident # 109 discharged from the facility on August 18, 2014.	2/16/15

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F 226	Continued From page 5 absence of the Administrator, of the details that are known at the time of the identification. Initial report is completed within 24 hours to North Carolina Health Care Personnel Registry (NCHCPR.) The investigation shall consist of: a) a review of the completed incident form, witness statements and abuse report form; b) an interview with the person(s) reporting the incident; c) interviews with any witnesses to the incident; d) interview the patient if patient is interviewable; e) interview other patients if indicated; f) interview staff members (on all shifts having contact with the patient during the period of the alleged incident); g) interview the patient's roommate, family members and other patients to which accused employee(s) provides care or services; h) a review of all circumstances surrounding the incident." Resident #109 was admitted to the facility on 06/12/14 with diagnoses that included congestive heart failure, hypertension, presenile depression and chronic pain syndrome. A Minimum Data Set (MDS) assessment dated 07/10/14 indicated the resident was cognitively intact for daily decision making and had no memory impairment. The MDS also indicated the resident did not refuse care or have any behavioral symptoms such as being verbally or physically abusive towards staff. According to the MDS, Resident #109 required limited assistance of 1 staff with bed mobility, transfers and toilet use, was occasionally incontinent of bladder and always continent of bowel. A care plan dated 06/13/14 and updated 07/23/14 addressed Resident #109's need for limited assistance with toileting needs and included an intervention which specified "place urinal within reach."	F 226	For residents with the potential to be affected by the alleged deficient practice the following has been achieved: The Director of Nursing is no longer affiliated with this facility. The Administrator, ADON, RN supervisor, and social worker were retrained by the Regional Nurse Consultant 1/26/2015 for following facility policy and procedure for allegations of abuse/neglect. All other department managers were in-serviced by the Regional Nurse Consultant 01/26/2015: In-service included following facility policy for reporting all allegations requiring investigation: abuse, neglect, diversion, fraud, misappropriation of property, injuries of unknown origin. Investigation begins immediately following critical elements: who, what, when, where. Direct care staff were re-in-serviced for facility policy for reporting and investigating allegations of abuse neglect by the Regional nurse consultant. Policy In-service included: screening of new employees for history of abuse neglect, criminal background check, drug screens, verifying credentials, professional license. Training, Prevention, how to identify potential situations, such as residents with behaviors such as combativeness and wandering. Reporting all allegations immediately to charge nurse, supervisor, administrator, or DON. Policy to thoroughly investigate all allegations within 24 hours. Protecting the resident while the investigation is underway. The following systematic changes have been implemented to prevent recurrence.	

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F 226	Continued From page 6 Review of the facility's abuse investigations revealed the facility received a report on 07/17/14 from a social worker at the local hospital stating that Resident #109 reported an incident had occurred about 3 nights prior to 07/17/14 when a nurse aide (NA) was mean to him and took his urinal and refused to bring him any water. According to documentation of the facility's investigation, the Director of Nursing (DON) met with the resident when he returned to the facility on 07/17/14 and Resident #109 made the following statement: "about 3 nights ago the NA took my urinal and told me I could not have any water because I used the urinal too much. She took the urinal and was gone for over 45 minutes. When she finally came back she had the urinal and some water. She then told me I had to make 3 deposits in the urinal before calling her to empty the urinal. I told her I didn't feel comfortable doing that because I may spill the urine. I didn't want to make a mess." The documentation indicated Resident #109 stated he hadn't reported the incident to anyone at the facility because he had a different NA the next night. According to the investigation documentation, the DON obtained a statement from NA #2, who was assigned to work with the resident on 07/14/14 on the night shift, and the NA denied the allegations. The DON also interviewed the nurse on duty on 07/14/14 on the night shift and she stated Resident #109 had not reported having his urinal taken or being denied water by NA #2. Review of Resident #109's medical record revealed documentation by the social worker of a care plan meeting with the resident and his family that was held on 07/18/14. According to the note Resident #109 denied any concerns or problems	F 226	Retraining of staff. Development of QA tool to track all allegations with the following information: brief description of the allegation & date received, date 24 hour form faxed with receipt (to ensure allegation reported within 24 hours), 5 day form completed and fax date with receipt, summary of investigation completed, written statements from others, comments and date and staff name completing the audit. The administrator reviews and transcribes all allegations of abuse neglect on the audit tool upon receipt of the allegation reviewing that policy was enforced. This new system will become a permanent part of the process for monitoring completeness for investigation and follow up to ensure a thorough investigation as is policy has been done. A quality assurance program was implemented under the supervision of the administrator to monitor all allegations of abuse/neglect to ensure facility policy is followed for allegations of abuse neglect. The Administrator is responsible to audit all allegations of abuse/neglect 5 days a week as they are reported so information may be monitored for compliance to ensure thoroughness and follow through with policy. Any concerns identified will be corrected immediately and addressed with the appropriate staff. .The administrator will document quality concerns with identified areas for deficiency concerning following of policy to the quality assurance committee quarterly for further corrective	

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F 226	Continued From page 7 with his care. An interview with the DON on 01/15/15 at 4:17 PM about the investigation of Resident #109's allegation revealed she had not interviewed staff from any other shifts who worked around the time of the alleged incident. The DON stated she had asked the house supervisor if there had been any complaints about NA #2 and there hadn't been any other complaints from residents or staff. She stated she didn't interview any other residents who received care from NA #2 but thought the social worker had interviewed 5 other residents An interview with the Administrator on 01/16/15 at 9:59 AM revealed the social worker did not interview any other residents about the care they received from NA #2. A second interview with the Administrator on 01/16/15 at 11:52 AM about his expectation for interviewing other residents, who had been provided care by an accused staff member, revealed whether or not other residents were interviewed depended on the situation. He offered no explanation for other residents not being interviewed following the allegation by Resident #109.	F 226	action.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		2/16/15

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F 242	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to honor a resident's choice to not have her shoe put on (Resident #197). The findings included: Resident #197 was admitted to the facility on 03/03/14 with diagnoses that included recent hip replacement, atrial fibrillation and hypertension. A Minimum Data Set (MDS) dated 03/31/14 indicated the resident was cognitively intact for daily decision making and had no memory impairment. The MDS also specified the resident did not refuse care or have any behavioral symptoms such as being verbally or physically abusive towards staff. According to the MDS, Resident #197 required limited assistance of 1 staff with dressing. A care plan dated 03/19/14 indicated Resident #197 needed limited assistance with dressing and listed as the goal that the resident would assist in dressing herself as able with staff providing assistance as needed. Review of the facility's grievances revealed a grievance form was received from Resident #197 on 04/19/14 by Nurse #1 when the resident returned to the facility from a visit with her family. The grievance form read as follows: "Resident states 'when the Nurse Aide (NA) was putting my shoe on my right foot I told her stop that hurts but she continued to force my shoe on.' Resident continues 'when we got home my responsible party (RP), a nurse practitioner, took the rest of my nail off." The grievance form indicated NA#1 was the staff member that had assisted Resident #197 with dressing. The grievance form indicated	F 242	F 242 It is this facility□s policy to acknowledge that each patient has the right to choose activities, schedules and health care consistent with his or her interests, assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the patient. Resident #1 no longer resides in facility and was discharged 05/07/2014. The aide initially involved with incident was no longer affiliated with facility when survey took place. To achieve compliance for other residents at risk for this alleged deficient practice, all direct care staff (licensed nurses and aides) have been in-serviced for resident rights to make choices by listening to and reacting to residents verbal expressions/concerns with respect. If the resident is expressing concern that pain is being experienced, stop and look at the area where resident states pain is. Always inform the nurse on unit so he/she may assess the area to ensure resident has no injury. Direct care staff in-serviced to be respectful and kind to residents honoring choices and individual rights. Staff in-serviced for facility responsibility	

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F 242	Continued From page 9 the Administrator met with the resident on 04/21/14 and the resident stated: "She was really twisting and shoving to get my shoe on. I said 'stop that hurts' - she just kept on. When I got to my RP's home and took off my shoe, there was blood on my sock. My toenail was hanging by a piece of skin and my RP had to remove it." Review of the nurse's notes for Resident #197 revealed an entry dated 04/19/14 at 7:43 AM by Nurse #2 which indicated Resident #197 was leaving at that time to go home with her family for the day. The note indicated she denied any pain or discomfort. A nurse's note dated 04/19/14 at 8:38 PM by Nurse #1 indicated the resident's RP reported the resident's right pinky toe nail was removed while attempting to place the shoe on her right foot that morning. According to the nurse's note the resident stated while the NA was attempting to put the resident's shoe on, the resident voiced discomfort and when they got home her RP, who is a nurse practitioner, looked at it and trimmed the rest of the toe nail off. Review of the nurse's notes prior to and following the incident did not reveal any documentation of Resident #197 having edema (swelling) in her feet. Review of a signed statement by NA #1 revealed she had no problem putting the shoe on Resident #197's left foot but she had difficulty putting the shoe on her right foot and had the resident push down to get her heel in the shoe. NA #1 denied the resident expressed pain or told her to stop. Written statements by other staff, who provided care to Resident #197, revealed she preferred to wear non-skid socks and complained that her shoes were too tight or uncomfortable. One of the	F 242	for responding to resident concerns, so they may be appropriately documented and reported as indicated. The following system has been set in place to prevent recurrence of this alleged deficiency and to enhance the process for concerns already in place. Retraining of direct care staff for honoring resident rights. Staff member receiving resident concerns, immediately informs charge nurse/supervisor so immediate attention is given to the concern voiced by the resident. The administrator logs resident concerns on a line list maintained in a notebook in administrator□s office. The administrator reviews the line list for new concerns 5 days per week in the morning meeting with the DON.ADON. The DON/ADON will follow incidents to ensure facility policy for honoring resident choices is followed and the resident is treated with dignity and respect. The administrator logs all grievances/concerns, 5 days per week, and reviews them with the DON/ADON 5 days per week in morning meeting. The administrator is responsible for monitoring compliance and any concerns will immediately be addressed. The administrator documents findings addressed and presents them to the Quality assurance committee quarterly for further review.	

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F 242	Continued From page 10 statements indicated Resident #197 had a problem with her feet swelling and complained of her shoes being uncomfortable when her feet were swollen. An interview with Nurse #1 on 01/16/15 at 9:24 AM revealed she recalled being made aware of the incident with Resident # 197's toenail being pulled loose on 04/19/14 about 8:30 PM. Nurse #1 stated the resident thought it happened when NA#1 was putting her shoes on that morning. Nurse #1 stated Resident #197 reported that she told NA#1 that it was hurting but Nurse #1 didn't recall Resident #197 reporting that she told NA#1 to stop. An interview with the Administrator on 01/16/15 at 6:22 PM about his expectation for nurses reporting any incident involving a resident that results in an injury revealed he expected the nurses to report incidents of that nature to the nurse on call. The Administrator stated he didn't have an explanation as to why Nurse #1 didn't report the incident in addition to completing a grievance form.	F 242		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow the care plan to initiate the	F 282	F 282	2/16/15

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F 282	Continued From page 11 bowel movement protocol for a resident with no bowel movement in 14 days and failed to keep a resident's bed in the lowest position for a resident with a history of falls for 2 of 25 sampled residents (Resident #92 and #140). The findings included: 1) Review of a document titled "Admission Protocols" with a revised date of 03/01/12 read in part the following: · Admission protocols are considered part of the initial care plan · Milk of Magnesia (MOM) 30 milliliters (ml) by mouth (PO): Give Day 3 if no bowel movement (BM) · Dulcolax 10 milligrams (mg) suppository: Give Day 4 if no BM from laxative · Enema: Give Day 5 if no BM from suppository Resident #92 was admitted to the facility on 09/26/14 with diagnoses which included diabetes mellitus, dementia with behavior disturbance, and constipation. Review of the physician's orders dated 09/26/14 included orders for constipation. The instructions specified for Resident #92 to be given MOM 30 ml orally on day 3 if no BM, Dulcolax 10 mg rectal suppository on day 4 if no BM from the MOM, and if no BM on day 5 from the suppository, give Enema one bottle rectally. Further review of the physician's orders revealed Senna Laxative 8.6 mg /2 tablets (17.2 mg) by mouth once daily as needed for constipation. A review of the Medication Administration Record (MAR) dated from 09/26/14 through 12/31/14 revealed Resident #92 had not received the	F 282	This facility has a policy to ensure services are arranged and provided to meet professional standards of quality and are provided by appropriate qualified persons (i.e. licensed, certified) and ensures appropriate discharge planning and communication for necessary information to the continuing care provider. One of the ways this was achieved for resident #92 is by re-training of licensed staff in December 2014 upon learning of the bowel protocol not being followed as per care plan. This resident□s care plan has consistently been followed for bowel elimination protocol as care planned and resident #92 has not experienced a recurrence. This was achieved for resident #92 and #140 by in-service to licensed nurses and certified nurse assistants to read, and utilize the care plan as tool to instruct/inform for individual resident needs. Each licensed nurse and nurse aide was re-in-serviced in January and February 2015 by the regional nurse consultant for importance of knowing the care plan and care guide applying information for each resident so each resident receives professional standard of quality. For other residents with potential to be affected by the alleged deficit practice, the following has been achieved: Licensed nurses and nurse aides were re-in-serviced by the regional nurse consultant in January and February 2015	

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F 282	Continued From page 12 medications MOM, Dulcolax, and/or an Enema, however the Senna Laxative 2 tablets by mouth was administered on 12/16/14. Review of the admission Minimum Data Set (MDS) dated 10/03/14 indicated Resident #92 demonstrated severe impairment of cognition, required extensive assistance with bed mobility and toileting, was totally dependent on staff for transfers, dressing, bathing, and personal hygiene, and required assistance with eating of a regular diet. Resident #92 was coded as being administered antipsychotic and antidepressant medications for 7 out of 7 days, and always incontinent of bowel and bladder. The MDS revealed that no medications were coded to be administered for the diagnosis of constipation. A care plan dated 10/07/14 specified Resident #92 was at risk for constipation due to dementia and a history of constipation. The care plan goal was for the resident to have a regular BM pattern. Care plan interventions included monitor and chart bowel movements and administer medications for constipation per physician's orders. A review of a Bowel Movement Monitoring Assessment Report dated 11/01/14 through 01/16/15 revealed no bowel movement was recorded for Resident #92 for 14 days from 12/01/14 through 12/14/14. A review of the Nurses Progress Notes dated 11/29/14 through 01/16/15 revealed no documentation to indicate a bowel movement assessment was completed and/or that the BM protocol had been initiated. Further review of the nurse's notes revealed Resident #92 was sent to	F 282	for facility protocol for reading the care guide and care plan in order to meet each resident□s needs. In-service included being familiar with and following plan of care for each resident to initiate bowel protocol as indicated. 3-11 nurse prints the bowel elimination report each night, after reviewing it and placing protocol in place as needed, the report is initialed and turned in to the DON for review. Another process added to enhance the current system in place is as follows: The DON/ADON prints the bowel elimination report daily times 2 weeks, printing a range of 3 days for review/audit to ensure nurses have initiated protocol for bowel elimination as care plan. Items identified as concerns are addressed with the nurse for immediate intervention. Then the DON/ADON prints the bowel elimination report 3 times weekly for 2 weeks, then it is printed 2 x weekly by the DON/ADON . Then the DON/ADON will print the report 2 x weekly at random to monitor and ensure compliance for following plan of care to meet resident individual needs to a professional standard of quality. A QA tool has been incorporated for daily rounds to ensure resident beds are in position as care planned, and environment is free of hazards that increase risk for falls or other injury. Findings of concern for bowel elimination are documented on the QA tool which has the following data: Only residents identified with concerns are logged on the form, last BM date, bowel protocol	

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F 282	Continued From page 13 the emergency room on 12/14/14 related to a fall. An interview was conducted on 01/15/15 at 6:12 AM with Nurse #8. She stated the Nursing Assistants (NAs) were expected to inform the nurses if a resident had not had a BM during their shift. She indicated at that time the nurse should do an assessment of the resident's abdomen, check for bowel sounds, and check the resident's medical record for verification of the last BM. She confirmed there was no documentation to indicate Resident #92 had a BM from 12/01/14 through 12/14/14. An interview on 01/15/15 at 12:29 PM was conducted with NA #4. She stated Resident #92 was given prunes every day at breakfast and that most of the time she would eat the prunes. She stated the NAs were expected to document in the computer when a resident had a BM or inform the nurse should a resident not have a BM by the end of their shift. She confirmed she had not documented a BM for Resident #92 from 12/01/14 through 12/14/14 and was unable to recall if she had informed a nurse of no BM. An interview on 01/15/15 at 1:39 PM was conducted with NA #3. She stated the NAs were expected to document in the computer system if a resident had a BM and/or inform the nurse if a resident had not had a BM by the end of their shift. She confirmed that she had not documented any BMs for Resident #92 from 12/01/14 through 12/14/14 and was unable to recall if she had informed the nurse of no BMs for Resident #92. An interview on 01/15/15 at 1:59 PM was	F 282	initiated, interventions initiated, results, care plan in place and followed, corrective measures, negative outcomes, and comments. Only residents with identified concerns are logged on the environmental form for safety issues and immediate intervention is required for safety risks identified as identified in care plan and visually with rounds. All care plans are update quarterly and as needed as new concerns are identified. The MDS nurses completed an audit February 6, 2015 to ensure care plan and care guide needs are updated with current interventions as indicated. The MDS nurses are responsible for care plan and care guide review and update these documents quarterly and prn. Care plans for each resident care needs are updated on an individual basis as needed when change is indicated as assessed by the licensed nurse. Care guides for the aides are further updated on as needed basis monthly prn to reflect current needs of the resident. The care guide is placed inside the resident closet so nurses are informed as to care needs. The DON/ADON is responsible for monitoring compliance by printing the bowel elimination report 3 times weekly for 2 weeks, then 2 times weekly by the DON/ADON. For continuing compliance, the DON/ADON will print the report at random following the first four weeks and report findings to quality assurance committee quarterly for review and further corrective action.	

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conducted with Nurse #5. He stated he was unable to recall if he had been informed by the NAs of no BM for Resident #92. He indicated Resident #92 was sent to the hospital for a fall and was diagnosed with a UTI and constipation, and after her return back to the facility, the nursing staff had an in-service and was advised that the 2nd shift charge nurse would initiate the BM protocol for those residents' who had not had a documented BM in 3 days. He stated he did not know why the BM protocol was not initiated for Resident #92 and he confirmed that no BM had been documented for Resident #92 from 12/01/14 through 12/14/14

An interview on 01/16/15 at 11:41 AM was conducted with Nurse #3. She stated she was the nurse responsible for Resident #92 on the 1st shift (7:00 AM through 3:00 PM). She confirmed Resident #92's BM protocol was signed by the resident's physician upon admission to the facility. She stated there was no documentation to indicate that Resident #92 had a BM from 12/01/14 through 12/14/14 or that the facility had initiated the BM protocol. She further stated she was not working on 12/14/14 but was aware that Resident #92 was sent to the hospital on 12/14/15 and that she was diagnosed with constipation and possible impaction. She indicated the nursing staff had an in-service in December, 2014 and was advised the 2nd shift charge nurse would initiate the BM protocol for those residents' who had not had a documented BM in 3 days. She stated she did not know why the BM protocol was not initiated for Resident #92.

An interview on 01/16/15 at 5:38 PM was conducted with the Director of Nursing (DON).

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She stated her expectation was that the facility BM protocol was to be followed, however the DON acknowledged the BM protocol was not followed for Resident #92. She stated she was aware of the grievance filed on 12/22/14 and the family had informed her of Resident #92's constipation and she had to have stool removed manually during her hospital admission. She stated she was unaware Resident #92 had not had a BM in 14 days but felt that having someone responsible for reviewing and initiating the BM protocol would alleviate any future problems. She stated she expected the nursing staff to follow the resident's care plan.

2) Resident #140 was admitted to the facility on 08/06/14 with diagnoses which included history of a hip fracture, high blood pressure, diabetes mellitus, chronic obstructive pulmonary disease, atrial fibrillation, and kidney disease.

Review of the quarterly Minimum Data Set (MDS) dated 11/10/14 indicated Resident #140 was cognitively intact and capable of making daily decisions. Resident #140 was coded to need limited assistance with personal hygiene and bathing, and extensive assistance with bed mobility, transfers, dressing, and toileting.

A care plan dated 12/16/14 specified Resident #140 was at risk for falls related to an unsteady gait and unsteady balance, history of falls, which included a hip fracture. The care plan goal was to keep the resident free from a fall related injury. Care plan interventions included call light within resident's reach, concave mattress, bilateral half side rails, and bed at lowest position while occupied.

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Review of Resident #140's medical record revealed an unwitnessed fall on 09/03/14 at 3:00 AM. The nurse's entry specified the resident was found on the floor near the bathroom door and Resident #140 had sustained skin tears to both elbows and that the physician and the resident's family were notified. Further review of the medical record revealed an intervention of toileting the resident every 2 hours.

Further review of Resident #140's medical record revealed a fall on 09/28/14 at 3:05 AM. The nurse's entry specified Resident #140 sustained an injury to the left hip due to the fall with an intervention which included a sensor pad to the resident's bed due to falls occurring at night. The resident's family and the physician were notified.

The medical record revealed Resident #140 had an unwitnessed fall on 01/06/15 at 3:10 AM. The nurse's entry specified the resident slid out of bed, into the floor, with his arm between the mattress and the side rail, the bed alarm was ringing and the resident was calling out for assistance. The nurse's entry indicated the physician and the resident's family were notified.

On 01/14/15 at 8:43 AM, Resident #140 was observed sitting up in bed eating breakfast with bilateral half side rails in the upright position, call light within reach, and the bed not in the lowest position but at waist level.

On 01/15/15 at 6:37 AM, Resident #140 was observed to be asleep, bilateral half side rails upright, and the bed was noted to be at waist level and not in the lowest position.

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On 01/15/15 at 10:12 AM, Resident #140 was observed sitting upright in bed with bilateral half side rails upright, call light within reach, and the bed was noted to be at waist level and not in the lowest position.

On 01/15/15 at 10:14 AM, an interview was conducted with Resident #140. He stated he was unaware the bed would go lower to the floor. He indicated the bed stayed in the same position all the time except when he ate his breakfast and the nursing assistant would raise the head of his bed up.

On 01/16/15 at 3:07 PM, an interview was conducted with Nursing Assistant (NA) #5. She stated she thought Resident #140 was a fall risk because he had a history of falls. She further stated should Resident #140 be a fall risk it would be indicated on his care guide which was located on the inside of his closet door. After reviewing the resident's care guide, she confirmed Resident #140 was at risk for falls and was to have his "bed at the lowest position while occupied." She indicated she had not placed Resident #140's bed in the lowest position as to not allow his catheter bag to touch the floor.

On 01/16/15 at 3:12 PM, an interview was conducted with NA #6. She stated the nursing staff was supposed to inform them if a resident was at risk for falls. She indicated she was unaware that Resident #140 was at risk for falls and that his bed was supposed to be kept at the lowest position.

On 01/16/15 at 3:31 PM, an interview was conducted with Nurse #7. She confirmed Resident #140's bed was at waist level and not in

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F 282	Continued From page 18 the lowest position. She manually lowered the bed to the floor to demonstrate the lowest position and stated the bed was supposed to be next to the floor at all times when occupied by Resident #140. On 01/16/15 at 5:38 PM, an interview was conducted with the Director of Nursing (DON). She stated she expected Resident #140's bed to be in the lowest position when occupied. She further stated she would have expected the nursing staff to have followed the resident's care plan.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, physician and staff interviews, and family interview, the facility failed to follow the bowel protocol and/or administer medications to a resident who had not had a bowel movement for 14 days for 1 of 5 sampled residents reviewed for unnecessary medications and the facility failed to follow a physician's order for wound care for 1 of 4 residents observed during wound care (Resident #92 and #30).	F 309	F 309 It is the policy of this facility that each patient receives and this facility will provide the necessary care and the services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	2/15/15

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F 309	Continued From page 19 The findings included: 1) Review of a document titled "Admission Protocols" with a revised date of 03/01/12 read in part the following: · Admission protocols are considered part of the initial care plan · Milk of Magnesia (MOM) 30 milliliters (ml) by mouth (PO): Give Day 3 if no bowel movement (BM) · Dulcolax 10 milligrams (mg) suppository: Give Day 4 if no BM from laxative · Enema: Give Day 5 if no BM from suppository Resident #92 was admitted to the facility on 09/26/14 with diagnoses which included diabetes mellitus, dementia with behavior disturbance, and constipation. Review of the physician's orders dated 09/26/14 included orders for constipation. The instructions specified for Resident #92 to be given MOM 30 ml orally on day 3 if no BM, Dulcolax 10 mg rectal suppository on day 4 if no BM from the MOM, and if no BM on day 5 from the suppository, give Enema one bottle rectally. Further review of the physician's orders revealed Senna Laxative 8.6 mg /2 tablets (17.2 mg) by mouth once daily as needed for constipation. A review of the Medication Administration Record (MAR) dated from 09/26/14 through 12/31/14 revealed Resident #92 had not received the medications MOM, Dulcolax, and/or an Enema, however the Senna Laxative 2 tablets by mouth was administered on 12/16/14. Review of the admission Minimum Data Set (MDS) dated 10/03/14 indicated Resident #92	F 309	Some of the ways this was achieved for resident #92 was by re-training of licensed staff in December 2014 upon learning of the bowel protocol not being followed as per care plan. This resident□s care plan has consistently and daily been reviewed for bowel elimination protocol as care planned and resident #92 has not experienced a recurrence. The licensed nurses were further in serviced by the regional nurse consultant during the months of January and February 2015 for following the care plan and physician orders, printing the bowel elimination report for a 3 day range, If resident has no BM documented in the 3 day range, initiate the bowel elimination protocol as ordered and care planned. If no results after 1st intervention, initiate 2nd intervention, if no bowel movement, initiate 3rd interventions, If bowel protocol not ordered, contact physician for orders. Licensed nurses instructed to assess resident abdomen and document assessment in narrative note, if resident complains of no bowel movement, or prescribed interventions have been ineffective. The nurse assistants were re-in serviced for daily documentation each shift for all needs including BM. Licensed Nurses are instructed it is their responsibility to manage the bowel protocol and print and review the bowel elimination summary report for each resident daily on 3/11 shift. Nurses and aides were trained it is staff responsibility to provide care and services to each resident in order to attain or maintain the	

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F 309	Continued From page 20 demonstrated severe impairment of cognition, required extensive assistance with bed mobility and toileting, was totally dependent on staff for transfers, dressing, bathing, and personal hygiene, and required assistance with eating of a regular diet. Resident #92 was coded as being administered antipsychotic and antidepressant medications for 7 out of 7 days, and always incontinent of bowel and bladder. The MDS revealed that no medications were coded to be administered for the diagnosis of constipation. A care plan dated 10/07/14 specified Resident #92 was at risk for constipation due to dementia and a history of constipation. The care plan goal was for the resident to have a regular BM pattern. Care plan interventions included monitor and chart bowel movements and administer medications per physician's orders. A review of a Bowel Movement Monitoring Assessment Report dated 11/01/14 through 01/16/15 revealed no bowel movement was recorded for Resident #92 for 14 days from 12/01/14 through 12/14/14. A review of the Nurses Progress Notes dated 11/29/14 through 01/16/15 revealed no documentation to indicate a bowel movement assessment was completed and/or that the BM protocol had been initiated. Further review of the nurse's notes revealed Resident #92 was sent to the emergency room on 12/14/14 related to a fall. A review of the dietary notes dated 12/01/14 through 01/16/15 revealed Resident #92 has had a decline in weight, with refusals to eat, and an intake of 0-25% with each meal.	F 309	highest practical physical, mental, and psychosocial well-being in accordance with the assessment and plan of care. Resident #92 has had daily review of all bowel elimination reviewed by the nurse on the unit and the regional nurse consultant since January 17, 2015, including weekends. For other residents with the potential to be affected by the alleged deficient practice. The licensed nurses were further in serviced by the regional nurse consultant during the months of January and February 2015 for following the care plan and physician orders, printing the bowel elimination report for a 3 day range, If resident has no BM documented in the 3 day range, initiate the bowel elimination protocol as ordered and care planned. If no results after 1st intervention, initiate 2nd intervention, if no bowel movement, initiate 3rd interventions, If bowel protocol not ordered, contact physician for orders. Licensed nurses instructed to assess resident abdomen and document assessment in narrative note, if resident complains of no bowel movement, or prescribed interventions have been ineffective. The nurse assistants were re-in serviced for daily documentation each shift for all needs including BM. Licensed Nurses are instructed it is their responsibility to manage the bowel protocol and print and review the bowel elimination summary report for each resident daily on 3/11 shift. Nurses and aides were trained it is staff responsibility	

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F 309	Continued From page 21 A review of hospital records dated 12/16/14 revealed Resident #92 was admitted to the hospital on 12/14/14 and discharged on 12/16/14. The record revealed Resident #92 was admitted to the hospital for a urinary tract infection (UTI), diverticulitis, abdominal pain, severe constipation. Further review of the hospital records indicated a section titled "Impression" which revealed there was severe fecal impaction in the rectum per the Computerized Tomography (CT) scan and the physician's diagnosis. Resident #92 was sent back to the facility with orders which included Senna Laxative, Miralax (a laxative), and 4 prunes with breakfast every day related to severe constipation. An interview was conducted on 01/15/15 at 6:12 AM with Nurse #8. She stated the Nursing Assistants (NAs) were expected to inform the nurses if a resident had not had a BM during their shift. She indicated at that time the nurse should do an assessment of the resident's abdomen, check for bowel sounds, and check the resident's medical record for verification of the last BM. She confirmed there was no documentation to indicate Resident #92 had a BM from 12/01/14 through 12/14/14 and she was unable to recall if she had been informed by an NA that Resident #92 had not had a BM. She stated the nursing staff had an in-service in December and was advised that the 2nd shift charge nurse would initiate the BM protocol for those residents' who had not had a documented BM in 3 days. She further stated she did not know why the BM protocol was not initiated for Resident #92. An interview on 01/15/15 at 12:29 PM was conducted with NA #4. She stated Resident #92 was given prunes every day at breakfast and that	F 309	to provide care and services to each resident in order to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the assessment and plan of care. To further enhance this process already in place the regional nurse consultant has printed and reviewed the bowel elimination report daily including weekends for all residents since January 17, 2015, reviewing the report and immediately addressing any concerns, both while in facility and calling the nurse on the weekends for concerns identified. Some of the ways this has been achieved for resident #30 is the wound care nurse was re-in serviced by the regional nurse consultant on 02/04/15 for following: physician treatment orders followed as directed by the physician, only the physician may change a treatment regimen once being notified by the nurse, all orders are transcribed and followed as directed by the physician. Only the physician gives permission to change a treatment order after being notified for any current concerns. For other residents with the potential to be affected by the alleged deficient practice, each licensed nurse was re-in-serviced to always follow physician orders, the licensed nurse must always consult the physician for any order concerns. All treatment orders were audited by the DON 2/9/15 to ensure physician orders are being followed and physician is contacted when an alternate intervention	

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F 309	Continued From page 22 most of the time she would eat the prunes. She stated the NAs were expected to document in the computer when a resident had a BM or inform the nurse should a resident not have a BM by the end of their shift. She confirmed she had not documented a BM for Resident #92 from 12/01/14 through 12/14/14 and was unable to recall if she had informed a nurse of no BM. An interview on 01/15/15 at 12:52 PM was conducted with the Regional Dietary Manager (RDM). She stated she was unaware Resident #92 had not had a BM for 14 days in December 2014. She further stated Resident #92 was to eat 4 prunes with her breakfast meal every day, was to be given a high calorie liquid supplement with each medication pass, a supplement called magic cup with each meal, and an appetite stimulant called Remeron related to her constipation, decrease in meal intake, and weight loss. An interview on 01/15/15 at 1:39 PM was conducted with NA #3. She stated the NAs were expected to document in the computer system if a resident had a BM and/or inform the nurse if a resident had not had a BM by the end of their shift. She confirmed that she had not documented any BMs for Resident #92 from 12/01/14 through 12/14/14 and was unable to recall if she had informed the nurse of no BMs for Resident #92. An interview on 01/15/15 at 1:59 PM was conducted with Nurse #5. He stated he was unable to recall if he had been informed by the NAs of no BM for Resident #92. He indicated Resident #92 was sent to the hospital for a fall and was diagnosed with a UTI and constipation,	F 309	is deemed needed based on assessment of the wound. To enhance current compliance and under the direction of the director of nurses, all licensed nurse staff were in serviced by the regional nurse director regarding state and federal requirements to provide care/services for highest wellbeing. Effective 02/02/15, under the supervision of the DON a quality assurance program was implemented to monitor application of wound treatment as ordered 2 residents /day, 5 days week for 2 weeks, and then 2 times week for 4 weeks, then weekly random checks of the licensed nurse and the CNAII for delivery of treatments as ordered following the physician order. All concerns are immediately addressed on the spot. Findings of the audit will be documented on the QA tool and submitted to the quarterly QA committee meeting for further review and corrective action.	

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and after her return back to the facility, the nursing staff had an in-service and was advised that the 2nd shift charge nurse would initiate the BM protocol for those residents' who had not had a documented BM in 3 days. He stated he did not know why the BM protocol was not initiated for Resident #92 and he confirmed that no BM had been documented for Resident #92 from 12/01/14 through 12/14/14.

An interview on 01/16/15 at 11:41 AM was conducted with Nurse #3. She stated she was the nurse responsible for Resident #92 on the 1st shift (7:00 AM through 3:00 PM). She confirmed Resident #92's BM protocol was signed by the resident's physician upon admission to the facility. She stated there was no documentation to indicate that Resident #92 had a BM from 12/01/14 through 12/14/14 or that the facility had initiated the BM protocol. She further stated she was not working on 12/14/14 but was aware that Resident #92 was sent to the hospital on 12/14/15 and that she was diagnosed with constipation and possible impaction. She indicated the nursing staff had an in-service in December, 2014 and was advised the 2nd shift charge nurse would initiate the BM protocol for those residents' who had not had a documented BM in 3 days. She stated she did not know why the BM protocol was not initiated for Resident #92.

An interview on 01/16/15 at 3:47 PM was conducted with Resident #92's family. The family stated they had met the resident at the hospital on 12/14/15 and Resident #92 was diagnosed with constipation and impaction.

An interview on 01/16/15 at 5:38 PM was

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conducted with the Director of Nursing (DON). She stated her expectation was that the facility BM protocol was to be followed, however the DON acknowledged the BM protocol was not followed for Resident #92. She stated she was aware of the grievance filed on 12/22/14 and the family had informed her of Resident #92's constipation and she had to have stool removed manually during her hospital admission. She further stated the nurses were provided an in-service related to the 2nd shift charge nurse initiating the BM protocol for those residents' with no documented BM in 3 days. She stated she was unaware Resident #92 had not had a BM in 14 days but felt that having someone responsible for reviewing and initiating the BM protocol would alleviate any future problems.

2. Resident #30 was admitted to the facility on 11/18/13 with diagnoses which included open wound of forearm, acute pain, high blood pressure, lung disease, depression, anxiety, muscle weakness and stroke. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/01/15 indicated Resident #30 had no short term or long term memory problems and was cognitively intact for daily decision making. The MDS further indicated Resident #30 required extensive assistance by staff for activities of daily living.

A review of a care plan titled skin integrity needs dated 11/14/14 indicated interventions in part for

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persistent skin lesions, dressing change every week on Monday, Thursday and Saturday and as needed for wound on left arm dorsal (forearm) until healed.

A review of a physician's order dated 11/20/14 indicated in part dermatology consult for persistent skin lesion.

A review of a nurse's progress note dated 12/12/14 at 4:34 PM indicated in part left forearm is noted to have improved with treatments 3 times a week and as needed dressing changes. The notes revealed the skin to this area is mostly intact with some very small superficial (located on the surface of the skin) open areas that are moist and the surrounding skin appears very fragile. The notes further revealed resident complained of tenderness.

A review of a handwritten physician's order from a Dermatologist (physician who specializes in treatment of skin conditions) dated 12/18/14 indicated in part chronic wound left forearm. Treat wound with Silvadene and non-stick gauze.

A review of a nurse's progress note dated 12/26/14 at 1:42 PM indicated in part the area on the left forearm was showing signs of improvement but had some areas that were superficially open.

A review of a nurse's progress note dated 01/12/15 at 1:25 PM indicated A&D (Vitamin A&D applied to the skin to moisturize and seal the skin) ointment applied to left forearm and monitor for changes.

A review of a nurse's progress note dated

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01/13/15 at 1:54 PM indicated A&D ointment applied to left arm prior to replacing dressing due to build-up of Silvadene Cream to help with moistening of area. The notes further indicated to continue to monitor and note any changes.

A review of a nurse's progress note dated 01/14/15 at 9:20 AM indicated in part left forearm wound continued with a small amount of Silvadene cream to arm but was improving with the use of A&D ointment. The notes also revealed there were some small open areas with a small amount of blood noted and Resident #30 complained of tenderness and discomfort during treatment and assessment and scheduled pain medicine was given prior to treatment.

During an observation of wound care on 01/15/15 at 2:12 PM the Wound Care Nurse (WCN) took a treatment cart into Resident #30's room, washed her hands, organized supplies on top of the treatment cart and put gloves on. She started to remove a non-stick dressing from Resident #30's left arm but the dressing was stuck to the wound. She picked up a spray bottle of wound cleanser and sprayed it on the dressing as she peeled the dressing off Resident #30's arm and then dabbed the wound with a gauze dressing. The wound was located on the top of Resident #30's left forearm from just above her wrist to below the crease in her arm at her elbow and was raw with open skin. There were also numerous small deeper open areas inside the area of raw skin that were oozing blood. The WCN picked up a packet of A&D ointment and squeezed the A&D ointment onto the glove of her hand and rubbed it onto the open wound on Resident #30's forearm. She placed a clean non-stick dressing on the wound and wrapped it with a gauze wrap and

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then discarded her supplies into a plastic trash bag, removed her gloves, washed her hands and took the treatment cart out of Resident #30's room.

During an interview on 01/15/15 at 2:35 PM the WCN explained when Resident #30 was admitted to the facility she had a cast on her left arm due to a fracture. She explained when the cast was removed several months later a skin tear was present on her arm. She stated they treated it but it was not responding so the wound doctor was consulted and ordered treatments and it healed. The WCN explained Resident #30 was admitted to the hospital in September 2014 and when she came back it looked like the superficial layer of skin was gone on top of her left arm. She stated the wound doctor looked at Resident #30's arm and recommended for her to see a Dermatologist and he ordered Silvadene cream and a non-stick dressing for her left arm. She explained the Silvadene cream had built up on the wound and was difficult to get off when she tried to clean it. She stated she had stopped using the Silvadene cream on the wound and had used the A&D ointment as a trial and error effort to soften and get the Silvadene cream off.

During a follow up interview on 01/16/15 at 10:37 AM the WCN confirmed she had not called the Dermatologist about her concerns with the Silvadene build up on the wound on Resident #30's left arm. She stated she should have called the physician and should have gotten a physician's order to use the A&D ointment. She explained she realized she had made an error by not following the physician's order and for not calling the physician to discuss her concerns about the wound.

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F 309	Continued From page 28 During a telephone call on 01/16/15 at 3:21 PM with the facility Medical Director he stated it was his expectation for nurses to follow physician's orders as written. He further stated if the nurse felt a treatment needed to be changed they should call the physician to discuss it and obtain an order before a treatment was changed. During an interview on 01/16/15 at 5:41 PM the Director of Nursing stated it was her expectation for nurses to follow physician's orders as they were written. She further stated if the nurse had a question about the order or wanted to change a treatment order they should call the physician first to discuss it and get a new order if the physician wanted the treatment changed.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to ensure a bed was maintained in the lowest position for a resident with a history of falls for 1 of 3 sampled residents reviewed for accidents (Resident #140). The findings included:	F 323	F 323 This facility has a policy that the patient environment should remain as free from accident hazards as is possible and that each patient receives adequate supervision and	2/15/15

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F 323	Continued From page 29 Resident #140 was admitted to the facility on 08/06/14 with diagnoses which included history of a hip fracture, high blood pressure, diabetes mellitus, chronic obstructive pulmonary disease, atrial fibrillation, and kidney disease. Review of the quarterly Minimum Data Set (MDS) dated 11/10/14 indicated Resident #140 was cognitively intact and capable of making daily decisions. Resident #140 was coded to need limited assistance with personal hygiene and bathing, and extensive assistance with bed mobility, transfers, dressing, and toileting. Further review of the MDS revealed Resident #140 required oxygen therapy, and was administered an anti-coagulant 2 out of 7 days and a diuretic 7 out of 7 days. A care plan dated 12/16/14 specified Resident #140 was at risk for falls related to an unsteady gait and unsteady balance, history of falls, which included a hip fracture. The care plan goal was to keep the resident free from a fall related injury. Care plan interventions included call light within resident's reach, concave mattress, bilateral half side rails, and bed at lowest position while occupied. Review of Resident #140's medical record revealed an unwitnessed fall on 09/03/14 at 3:00 AM. The nurse's entry specified the resident was found on the floor near the bathroom door and Resident #140 had sustained skin tears to both elbows and that the physician and the resident's family were notified. Further review of the medical record revealed an intervention of toileting the resident every 2 hours.	F 323	assistance devices to prevent accidents. Review of resident #140 medical record reveals no further incidents have occurred since the incident dated 01/06/15 and documented in the survey report. Some of the ways this is accomplished for resident #140 is as follows: All facility departments in-serviced by the regional nurse consultant, for resident safety. Licensed nurses and aides were re trained to read care plans, and care guides, applying safety interventions as documented in order to maintain resident safety. This training was a broad review of resident safety with focus on residents who fall and bed positioning when resident in bed. Staff were educated that residents beds are to be in low position when the bed is occupied. Resident # 140care plan and care guide reviewed and reflective of need for low position when in bed. For other residents with the potential to be affected by this alleged deficient practice the following has been achieved: Licensed nurses and nurse aides were re-in serviced for resident safety and bed position when occupied to low level. Follow care plan and care guide instructions/interventions for resident safety. Nurses oversight residents when in bed during medication pass and rounds to ensure beds in low position. The MDS nurses did a 100% audit of current residents in the past 30 days with any type of incident and updated care plans and care guides as indicated. Staff were in	

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F 323	Continued From page 30 Further review of Resident #140's medical record revealed a fall on 09/28/14 at 3:05 AM. The nurse's entry specified Resident #140 sustained an injury to the left hip due to the fall with an intervention which included a sensor pad to the resident's bed due to falls occurring at night. The resident's family and the physician were notified. The medical record revealed Resident #140 had an unwitnessed fall on 01/06/15 at 3:10 AM. The nurse's entry specified the resident slid out of bed, into the floor, with his arm between the mattress and the side rail, the bed alarm was ringing and the resident was calling out for assistance. The nurse's entry indicated the physician and the resident's family were notified. On 01/14/15 at 8:43 AM, Resident #140 was observed sitting up in bed eating breakfast with bilateral half side rails in the upright position, call light within reach, and the bed not in the lowest position but at waist level. On 01/15/15 at 6:37 AM, Resident #140 was observed to be asleep, bilateral half side rails upright, and the bed was noted to be at waist level and not in the lowest position. On 01/15/15 at 10:12 AM, Resident #140 was observed sitting upright in bed with bilateral half side rails upright, call light within reach, and the bed was noted to be at waist level and not in the lowest position. On 01/15/15 at 10:14 AM, an interview was conducted with Resident #140. He stated he was unaware the bed would go lower to the floor. He indicated the bed stayed in the same position all the time except when he ate his breakfast and	F 323	serviced to visually monitor bed height and other potential safety hazards when making rounds and providing care. Staff instructed to intervene immediately for any concerns identified and inform DON for further intervention as indicated. Effective 02/02/15 and to enhance the currently compliant operations walking rounds are completed daily for monitoring of resident rooms for hazards including bed position (height)by the DON/ADON all concerns for resident safety are immediately addressed with staff involved. The DON/ADON is responsible for compliance and documents and submits a quarterly report to the QA committee for further review or corrective action.	

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the nursing assistant would raise the head of his bed up.

On 01/16/15 at 3:07 PM, an interview was conducted with Nursing Assistant (NA) #5. She stated she "thought" Resident #140 was a fall risk because he had a history of falls. She further stated should Resident #140 be a fall risk it would be indicated on his care guide which was located on the inside of his closet door. After reviewing the resident's care guide, she confirmed Resident #140 was at risk for falls and was to have his "bed at the lowest position while occupied." She indicated she had not placed Resident #140's bed in the lowest position as to not allow his catheter bag to touch the floor.

On 01/16/15 at 3:12 PM, an interview was conducted with NA #6. She stated the nursing staff was supposed to inform them if a resident was at risk for falls. She indicated she was unaware that Resident #140 was at risk for falls and that his bed was supposed to be kept at the lowest position.

On 01/16/15 at 3:31 PM, an interview was conducted with Nurse #7. She confirmed Resident #140's bed was at waist level and not in the lowest position. She manually lowered the bed to the floor to demonstrate the lowest position and stated the bed was supposed to be next to the floor at all times when occupied by Resident #140.

On 01/16/15 at 5:38 PM, an interview was conducted with the Director of Nursing (DON). She stated she expected Resident #140's bed to be in the lowest position when occupied.

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F 333	Continued From page 32	F 333		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and physician interview the facility failed to prevent a significant medication error by administering the incorrect frequency of an antidiuretic (Lasix) for congestive heart failure in 1 of 8 residents reviewed for medication administration (Resident #176). The findings included: Resident #176 was admitted to the facility on 01/09/15 with diagnoses which included congestive heart failure, acute respiratory failure, and high blood pressure. The 5 day admission Minimum Data Set (MDS) dated 01/16/14 indicated Resident #176 was cognitively intact and was capable of daily decision making. A review of a document titled "Physician Orders Discharge Medication Reconciliation" dated 01/09/15, was sent to the facility by fax from a local hospital and was the same document sent with the resident to the facility which indicated "Lasix tablet (furosemide) Dose/Instructions 40 milligrams (mg) oral." No frequency was indicated on the order. During medication administration observation on 01/14/15 at 9:03 AM Nurse #4 administered Lasix 40 mg one tablet by mouth to Resident #176.	F 333	F 333 This facility will ensure that patients are free of any significant medication errors. This was achieved for resident #176 by achieving the following. The Lasix order was clarified with the physician during the annual state survey. The nurse involved was in serviced by the DON and regional nurse consultant for calling the physician for any orders written with directions such as , as directed to be clarified at the time the order is received by the physician. All orders for meds must be specific with details for accurate administration. All orders must be clarified when in doubt. Medications for resident #176 have been reviewed and found to be entered as ordered by the physician. For other residents with the potential to be affected by the alleged deficient practice the following has been achieved. Admissions since 01/18/15 were audited by the MDS nurses for accurate transcription into the electronic health record. All concerns were immediately clarified with the physician as needed and addressed with the nurse who did the	2/16/15

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F 333	Continued From page 33 Further observation of the medication label on the bubble pack indicated Lasix 40 mg to take 1 tablet by mouth twice a day. A review of the Medication Administration Record (MAR) dated for January 2015 revealed Resident #176 was administered Lasix 40 mg daily at 9:00 AM from 01/10/15 through 01/16/15. During review of the physician's orders (reconciliation) dated 01/09/15 revealed an order entry by Nurse #6 for Lasix 40 mg tablet by mouth (PO) daily due to respiratory failure. During an interview on 01/14/15 at 11:13 AM, Nurse #4 verified the pharmacy label affixed to the medication package for Resident #176 read in part Lasix 40 mg to take 1 tablet by mouth twice a day. However she compared the order on the pharmacy label with the administration record on the MAR on her computer screen which indicated the resident was administered Lasix 40 mg 1 tablet by mouth daily. She stated she worked the 7:00 AM to 3:00 PM shift and indicated the MAR that appeared on her computer screen was set up to show the times and the medications for which she was to give and she would not see the administration times for a medication if it was to be given on 2nd or 3rd shifts. During a telephone interview on 01/16/15 at 8:13 AM, the Pharmacist indicated they received the document titled "Physician Orders Discharge Medication Reconciliation" from the hospital and the same document from the facility via fax with Resident #176's medications listed. She verified the physician's order read in part "Lasix tablet (furosemide) 40 mg oral" and no frequency was	F 333	original entry in the computer. Nurses were in serviced using North Carolina nurse practice act for orders and the licensed nurse responsibility for accuracy of input. They were further instructed in professional standard and expectations of order entry. To enhance the current compliant operations and under the direction of the director of nurse, all nurses were trained in the triple check system for accuracy of orders as follows: Nurse review physician orders and enters them into the computer as clarified when needed and ordered by the physician, the nurse entering the order requisitions the medication order in the electronic record as policy. A second review of the order is reviewed by another nurse to ensure accurate entry into the electronic record, a 3rd review is followed by a licensed nurse to audit accuracy of entry. To accomplish required monitoring of said corrections under the supervisiion of the DON, 10 orders weekly are audited for accuracy via triple check for two weeks. Only discrepancies are logged on the QA tool. For the next two weeks, 5 orders are checked for accuracy weekly via triple check. Following, random orders will be checked for accuracy via triple check for three months. All identified concerns are immediately corrected and addressed with nurse involved. The DON is responsible for compliance and documents findings which	

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F 333	Continued From page 34 indicated. She stated the resident was administered Lasix 40 mg intravenously (IV) twice a day while in the hospital and they labeled the medication on the bubble pack for Lasix 40 mg by mouth twice a day. She indicated if Lasix was to be administered twice a day via IV then it would not be cut down to once a day by mouth especially for a resident diagnosed with heart and respiratory failure. The pharmacist further indicated she assumed since the resident had received Lasix twice a day via IV the oral form would stay twice a day. She stated she had not contacted the physician for frequency verification of the Lasix. During a telephone interview on 01/16/15 at 2:18 PM, the Physician stated he expected Resident #176 to be administered the Lasix 40 mg by mouth twice a day related to her diagnoses of heart and respiratory failure. He further stated he had not received a call from the pharmacist or the nursing staff related to a discrepancy in the frequency of the Lasix for Resident #176. During a telephone interview on 01/16/15 at 2:53 PM with Nurse #6, she verified her initials on the document beside the order for "Lasix tablet (furosemide) Dose/Instructions 40 milligrams (mg) oral" dated 01/09/15 with no frequency indicated, however she had recalled an order for Lasix to be administered daily. She further stated she was unaware of an order for Lasix 40 mg by mouth with a frequency of twice a day nor had she contacted the physician for frequency verification of the Lasix. During an interview on 01/16/15 at 3:21 PM with Nurse #7, she verified her initials on the document beside the order for "Lasix tablet	F 333	are submitted to the QA committee quarterly for review and further corrective action.	

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F 333	Continued From page 35 (furosemide) Dose/Instructions 40 milligrams (mg) oral" dated 01/09/15. She stated the physician's orders received from the hospital via fax and the physician's orders that was sent to the facility with Resident #176 were reconciled and the 2 order sets were the same. She indicated she was unaware of a discrepancy in the frequency of the Lasix. She verified there was no frequency noted on the physician's orders and that she or Nurse #6 should have called the physician for clarification, however she indicated she had not contacted the physician for frequency verification of the Lasix. She further stated Resident #176 was getting Lasix once a day from a previous admission in November 2014 and that was their reason for putting the frequency at once a day for this particular admission. During an interview on 01/16/15 at 5:38 PM with the Director of Nursing (DON), she stated she expected the nurses to check and verify all pharmacy labels with the physician's orders. She further stated she expected the nurses to call the physician for clarification if an order was noted to be incomplete.	F 333		
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		2/16/15

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F 520	Continued From page 36 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in September 2013. This was for three re-cited deficiencies that were originally cited on a recertification survey in September 2013 and on a recertification survey on January 16, 2015. The deficiencies were in the areas of investigating and reporting allegations of abuse and neglect, developing and implementing abuse and neglect policies and medication administration. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment Assurance Program. The findings included: This tag is cross referenced to:	F 520	F 520 This facility has a corporate policy to maintain a quality assurance and assessment committee. (This may be known as Quality Improvement or QAPI - Quality Assurance Process Improvement) and serves as an on-going process, multi-level, and facility-wide. The purpose of the QAA is continuous evaluation of facility systems with specific objectives. This committee meets at least quarterly and consists of the director of nursing, medical director, and at least 3 other members of facility staff as required per state and federal regulation. It is the policy of this facility the QA committee, develops, implements appropriate plans of action to correct identified quality	

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F 520	Continued From page 37 F225: Investigate and Report Allegations of Abuse and Neglect: Based on record review and staff interviews the facility failed to thoroughly investigate an allegation of abuse by staff for 1 of 3 residents reviewed for abuse. F226: Develop and Implement Abuse and Neglect Policies: Based on record review and staff interviews the facility failed to follow their abuse policy for investigating an allegation of abuse by staff for 1 of 3 residents reviewed for abuse. F333: Pharmaceutical Services: Based on observations, record review and staff interviews the facility failed to accurately dispense medications as ordered for 2 of 11 residents whose medications were reviewed. During the last recertification survey in September 2013, the facility was cited for F225 for failing to report an allegation of abuse to the North Carolina Health Care Personnel Registry (NCHCPR), F226 for failing to follow their Abuse and Neglect Policy on reporting all allegations of abuse and neglect to the NCHCPR and F333 for failing to administer medications accurately and as they were ordered. On the survey of January 16, 2015 the facility was cited for failing to thoroughly investigate an allegation of abuse, failing to follow their abuse policy for investigating an allegation of abuse and failing to administer medications accurately in accordance with current physician's orders. During an interview on 01/16/15 at 6:22 PM with the Administrator, he stated the felt like the facility had worked really hard on the areas that were cited on the September 2013 survey and he thought they had corrected the problem with	F 520	deficiencies. To achieve compliance with the alleged cited repeat deficiencies the following has been initiated: The administrator and department managers have been retrained for the QA process by the regional nurse consultant using the following QAPI 5 elements: (Summary of training): 02/05/15 Design/scope: program must be ongoing and comprehensive, deals with full range of services offered by facility, including full range of departments. Addresses systems of care and management practices, including clinical care, quality of life, and resident choice. Aims for safety, high quality with clinical interventions. Governance and Leadership: governing body develops culture involving leadership and seeks input from staff, residents, and families or representatives. Designates 1 person responsible for QAPI developing leadership and facility wide training, sets expectations around safety, quality rights, choice, and respect. Feedback: data systems & monitoring: Incorporate feedback systems, monitors care processes, outcomes, reviews, tracks, and investigates, implements plans to prevent recurrence. Performance improvement Projects :(PIPS): concentrates on particular problems, gathers information, monitors, care process, outcomes, and tracks, and	

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F 520	Continued From page 38 reporting and investigating abuse. He had no comment on the continued non-compliance with F333 and stated they will continue to work on improving the areas of concern.	F 520	investigates. Systematic analysis and systemic action: develops policies annual procedures, demonstrates proficiency in cause analysis, reviews systems to prevent recurrence and promote sustained improvement. Focus on continual learning and continuous improvement. The Administrator, ADON, RN Supervisor and Social Worker and all other department managers were retrained by the Regional Nurse Consultant on 1/26/2015. The DON is longer affiliated with this facility. Training included allegations requiring investigation, abuse, neglect, diversion, fraud, misappropriation of property and injuries of unknown origin. Investigation begins immediately following critical elements: who, what, when and where. Document all steps taken during investigation, statements from the alleged victim, accused person and other pertinent information. Statements of other residents and staff as indicated according to the allegation. Summarize the information collected, document action taken against the accused personnel, whether investigations were conducted by other state agency or police department and outcome of the investigation. Submitting 24 hour report for allegation timely within the first 24 hours and follow-up with the 5 day allegation form. Systemic changes have been implemented to assure that the practice does not recur as follows:	

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F 520	Continued From page 39	F 520	A QA Audit Tracking Tool was developed to accompany each allegation which insures consistent use of all proper components of the investigative process. Pending and/or processing allegations of abuse will be reviewed by the administrator daily 5 days per week at the morning meeting of the management team and give a report on the progress and status of each open allegation. To monitor the facility□s performance, the administrator will be responsible for auditing all allegations of abuse/neglect 5 days/week as they are reported so information may be monitored for compliance to ensure thoroughness of information for the investigation including resident involved, other resident interviews, and staff interviews from all shifts indicated. Any concerns identified will be corrected immediately. The administrator will document quality concerns with identified areas or deficiency to the quality assurance committee for further corrective action. Corrective action for (F333) with regard to Quality Assessment and Assurance is as follows: The facility will ensure that patients are free of any significant medication errors. This was achieved for resident #176 by clarifying the medication order with the physician during the state survey. Admissions since 1/18/15 were audited for accuracy by the MDS nurses for accurate transcription into the electronic	

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F 520	Continued From page 40	F 520	health record. All concerns were immediately clarified with the physician as needed and addressed with the nurse who did the original entry in the electronic health record. Nurses were in-serviced using the North Carolina Nurse Practice Act for orders and the licensed nurse responsibility for accuracy of input. They were further instructed in professional standard and expectations of order entry. To enhance the current compliant operations and under the direction of the Director of Nurses, all nurses were trained in the triple check system for accuracy of orders as follows: The nurse reviews orders and enters them into the electronic health record as clarified with the physician when needed. The nurse entering the order requisitions the medication order in the electronic health record as per policy. A second review of the order is conducted by a licensed nurse to ensure accurate entry into the electronic health record. Finally, the order is reviewed by a third licensed nurse for accuracy of entry. All identified concerns are immediately corrected and addressed with the nurse involved. The DON is responsible for compliance and documents any findings which are reported to the Quality Assessment and Assurance Committee quarterly for review and further corrective action. To accomplish required monitoring of said corrections under the supervisiion of the DON, 10 orders weekly are audited for accuracy via triple check for two weeks.	

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F 520	Continued From page 41	F 520	Only discrepancies are logged on the QA tool. For the next two weeks, 5 orders are checked for accuracy weekly via triple check. Following, random orders will be checked for accuracy via triple check for three months.	