

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

PRINTED: 07/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/22/2015
NAME OF PROVIDER OR SUPPLIER BRANTWOOD NH & RETIREMENT CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 1038 COLLEGE STREET OXFORD, NC 27565		
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F 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to ensure notification of the physician of a resident ' s</p>	F 157	For Resident #148, who is a current resident in the facility, resident care planned relating to falls, for staff to	6/19/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/17/2015

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 157	<p>Continued From page 1</p> <p>unwitnessed fall from bed for one of four sampled residents (Resident #148) reviewed for accidents. Findings included: Resident #148 was admitted to the facility on Friday, 5/1/15 from a hospital with diagnoses that included generalized weakness, urinary tract infection, diabetes, dementia, acute renal failure and failure to thrive. The nurse Admission Note written by Nurse #1 on 5/1/15 at 6:58 pm stated Resident #148 " Arrived at this facility at approximately 3:30 pm. Being admitted with generalized weakness, failure to thrive, dementia, [urinary tract infection], [acute renal failure]. Resident is confused. He has a hard time hearing and you have to talk really loud to him. " Review of the Fall Log for May 2015 revealed Resident #148 had an " unwitnessed fall with injury " on 5/1/15. Review of the Fall Scene Investigation Report completed on 5/1/15 by Nurse #1 indicated the following:</p> <ul style="list-style-type: none"> · Resident #148 was alone and unattended at the time of the fall from his bed at 8:40 pm, he was " confused " , and stated he " needed to get out and go bake a cake. " · The resident ' s fall occurred " next to transfer surface [bed]. " Instructions on the report stated to " assess postural hypotension " (a form of low blood pressure that happens upon standing from sitting or lying down that can result in dizziness or fainting) and " if fall within 5 feet of transfer surface do orthostatic [blood pressure] (blood pressure that is taken while the resident is lying down, then repeated after several minutes with the resident sitting up, then repeated after several minutes again while the resident is standing.) · " Yes " was checked at question asking if 	F 157	<p>anticipate/meet the needs of the resident, maintain call light within reach, educate the resident/family/caregivers of safety reminders, keep frequently used items within reach, ensure pad alarm in place and follow the facilities fall protocol.</p> <p>To ensure the deficient practice does not reoccur for resident #148 or other residents, the physician will be notified verbally using the SBAR (Situation, Background, Assessment, and Request) communication tool for any fall for a resident. If the Physician cannot be reached within 30 minutes of a call, then the medical director will be contacted. Any orders or information that the Physician gives will then be transcribed to a telephone order sheet and signed by the nurse receiving the order and verified by another nurse who initials the order. A copy of the telephone order sheet will then be placed in the Clinical Nurse Managers mailbox which is checked by 9:00 AM each morning and several times throughout the day.</p> <p>Additionally, the nurse will also send out an alert in the Electronic Health Record system(which is our staff electronic communication board) so that staff is aware that a resident has fallen. In the Electronic Health Record under assessments, the nurse will select the fall alert option, check yes that a fall has occurred and save. Once the alert is saved, it appears on the dashboard to alert staff that a fall occurred.</p>		

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F 157	Continued From page 2 vital signs were " out of normal range for this resident " and orthostatic [blood pressures] were not done. There were no vital signs documented anywhere on the form or in the resident ' s chart until approximately 6 hours after the fall. · There was no root cause of Resident #148 ' s fall noted or interventions to prevent further falls. There were no fall team meeting notes on the report or indication of any review by the fall team. · The report noted the physician and responsible party were notified Review of the nurse notes for Saturday, 5/2/15 - Sunday 5/3/15 revealed Resident #148 was incontinent of bowel and bladder, restless " (moving around in bed some calling out). " The notes further indicated the resident was total care with his activities of daily living and that there were no complaints of pain. There were no nurse ' s notes until a late-entry note on 5/4/15 about Resident #148 having a fall on 5/1/15. Record review of the Medication Administration Record for 5/1/15-5/4/15 revealed Resident #148 did not receive any pain medication. The Late Entry nurse note written by Nurse #1 on Monday, 5/4/15 indicated it was an Incident Note for 5/1/15 at 10:00 pm. The late entry incident note stated, " The resident across the hall called out for help. I went to room and [Resident #148] had slid to the floor beside the bed. He stated, ' I screwed up. ' Vitals and assessment were done before the resident was put back to bed. He was assessed more thoroughly after being placed back in bed. There were no scratches, bruises, red areas or anything showing at that time. Also, when palpated at this time there were no facial grimaces or signs of pain. [Responsible party] was called, no answer. [Family member #3] was called, made aware. " During an interview on 5/20/15 at 3:04 pm with	F 157	Finally, the on-call nurse is part of the administrative nurse team who takes call on a weekly basis and is to be notified of any fall within 30 minutes of a fall. The Clinical Nurse Manager supervise all operations in the building when nursing administrative staff is not present. The Clinical Nurse Manager will assure compliance by verifying that the Physician has been notified by reviewing the telephone order or by calling the Physician. Any non-compliance will be reported to the DON or Administrator and taken to QAPI (Quality Assessment Performance Improvement) for review and further action as needed. The Clinical Nurse Manager or designee will monitor for compliance. Any non-compliance will be reported to QAQI (Quality Assessment Quality Improvement) Committee to determine follow up action/new plan. A review of incident reports, stand up meeting minutes, Rehab screen referrals and MDSs of all current residents to identify any resident having a fall since May 1, 2015 to assure the physician was notified. This process was completed by 5:00PM May 22, 2015. All nurses and CNAs were in serviced by May 27, 2015. In service included a review of Policy P3.1 "Falls Notification to the Physician" to inform nurses that the MD is to be called for all falls and faxing the MD is no longer permissible for falls.		

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F 157	Continued From page 3 Nurse #1, when asked about the events surrounding Resident #148 ' s fall on 5/1/15, she indicated she was doing the medication pass when the resident across the hall from Resident #148 called out for help because she saw Resident #148 fall out of bed. Nurse #1 stated, " I locked the cart and went to the room. He was sitting beside the bed and said ' I messed up. ' I assessed him on the floor, got vitals and got help to put back in bed. I checked him head to toe. We rolled him over. There were no bruises or obvious injury. He denied hurting. He was in the bed before he was found on the floor. He was sitting on the floor with his back to the bed and the bed was in the lowest position. There were no other falls preventions in place like an alarm. " When asked if she did neuro checks (a brief neurological exam done in intervals for a time period after a head injury) or other assessments after his fall Nurse #1 stated, " If he was laying flat on the floor then I would have done neuro checks but he was sitting, not laying on the floor. He can reposition himself in bed some. I did not do neuro checks. He rolled over for me during the admission assessment. I filled out the incident report, called his wife but didn ' t get an answer and called the 2nd number to inform. I filled out the form to send to [Physician #1] but it is my understanding that she did not get it. " Nurse #1 indicated she thought she faxed [Physician #1] around 10:30 pm to notify her of the 8:40 pm fall on Friday, 5/1/15 but could not definitively recall. Nurse #1 further stated, " I palpated [Resident #148 ' s] hips and his whole body but there was no indication of pain. I had no phone contact or faxed confirmation that the physician was notified. I have heard by the rumor in the facility that she was not notified. " Nurse #1 indicated she worked the following day, 5/2/15,	F 157	Nurse #1 was in serviced on May 21, 2015.		

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F 157	Continued From page 4 but was working on another hall, not with Resident #148. Nurse #1 also stated, "[Nurse Aide (NA) #3 and NA #4 helped me get him back in bed. I went back in before I left to re-check him. I cannot remember telling the nurse I gave report to, Nurse #5, about the fall. I can ' t remember if I did or I didn ' t. I did not put mats on floor or an alarm on the bed after the fall. I did an incident report in the computer on Friday but it disappeared so I came back in and put it in Monday. I did the paper report Friday. I did not report it to anyone that night. I would not call to report [to the physician] unless there was an injury. The report was put in the Director of Nursing (DON) box when I left. She had it Monday morning when I came back in. I am not aware that I am supposed to let the DON know or call the doctor if there is no injury. " During an interview on 5/21/15 at 1:13 pm with NA #3 she indicated she assisted Resident #148 back to bed on 5/1/15 after his fall. She further indicated he showed no indication of pain that she could recall, but " he kept asking for his wife. " During an interview on 5/21/15 at 3:22 pm with NA #4 she indicated she assisted Resident #148 back to bed on 5/1/15 after his fall and stated, " He didn ' t seem to be hurt. I changed him later and he was swinging his arms some so I asked someone to come help me because he is such a tall man. " During an interview with Nurse #6 on 5/22/15 at 3:15 pm she indicated she worked night shift on 5/1/15 and stated, " I came in at midnight that night and worked until 7 am. At the beginning of my shift about 1 am when the aide was doing her rounds she told me (Resident #148) was restless. I checked on him and he was restless but did not seem to be in pain, no moaning. He slept the rest of the night. I got report from [Nurse #5]. She did	F 157			

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F 157	<p>Continued From page 5</p> <p>not tell me anything about him falling. If I had known that he had fallen then I would have looked at him even more thoroughly through the night. " She indicated there were no nurse ' s notes when she worked that night about Resident #148 having a fall on 5/1/15.</p> <p>During an interview on 5/19/15 at 1:42 pm with Family Member #1 she stated, " [Staff] called me Friday night and said they checked him out and he had no injury. "</p> <p>During an interview on 5/19/15 at 1:45 pm with Family Member #2 she indicated she and Family Member #4 were at the facility and visited Resident #148 over the weekend. Family member #2 stated, " [Resident #148] wasn ' t talking much over the weekend but had his hand on his leg. On Monday I came in, tried to move his left leg over and he yelled out. I told the nurse I knew something was wrong. I said ' I know this man. ' I asked the head nurse, the director or something, about a written report about his fall. She said the nurse that was on duty had not written up anything. That was Monday. "</p> <p>During an interview with Nurse #2 on 5/21/15 at 9:30 am she indicated she was the first-shift nurse assigned to Resident #148 on 5/2/15-5/4/15. She stated, " I didn ' t know he had fallen on Friday. On Sunday his wife told me he had fallen when he came in Friday. The rehab therapist on Sunday said he could not stand him up because he was hurting. That was when we were changing shifts about 3pm. The resident never seemed to be hurting to me that weekend. He was new and report was he was non-ambulatory so we did not try to get him up that weekend. We would usually wait to get [a new admission resident] up until rehab evaluates to see what they need. I could never find the transfer assessment in the computer. His wife</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>was talking about his pain that Sunday morning and said, ' He says he hurts. ' When I asked him he never said he was hurting. Nobody reported any pain to me during his care. I could not find a note or anything about a fall from Friday. I looked at the nurse ' s notes but there wasn ' t one about a fall. He seemed to be in more pain Monday than on Sunday. " Nurse #2 indicated when there is a fall the nurse should notify the doctor, the family member, make a nurse ' s note in the computer, and complete the fall report by the end of the shift. Nurse #2 indicated she did not report a fall to the physician for Resident #148 over the weekend, but contacted the physician on Monday morning. During an interview with Nurse Aide (NA) #1 on 5/20/15 at 1:49 pm she stated, " I worked with [Resident #148] on Saturday (5/2/15) first shift. [Family member #2] was here that morning and a male relative was here in the afternoon. [Resident #148] was incontinent of bowel and bladder. I was giving him his bath and turned him to the left side. He said, ' I hurt so bad ' and was holding his left leg. I told him I would let the nurse know. I told her. It was [Nurse #2]. It was in the morning when I was doing my baths, but I don ' t remember exactly what time. "</p> <p>During an interview with NA #2 on 5/20/15 at 2:00 pm she indicated she worked on Sunday, 5/3/15, first shift with Resident #148. She stated, " In the morning I was trying to wash his feet and legs. He tried to go for his left leg like he was trying to keep me from moving him. [Family member #2] was here and told me he had a fall that Friday. I reported it to Nurse #2 and I went to the supervisor (Nurse #3). I let her know about his fall and that his wife wanted an alarm. Nurse #3 said she did not know about the fall, then Nurse #3 and Nurse #2 talked to each other. He did not</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>have an alarm or anything on Sunday. I put the floor mats down on Monday. He still was hurting on Monday." The aide indicated that the resident 's reaction on Sunday was of obvious pain with any movement of his left leg. During an interview on 5/21/15 at 10:22 am with Nurse #3 she indicated she was the weekend nurse supervisor who worked on 5/2/15-5/3/15 and stated, " I work every other weekend. I don ' t recall knowing about [Resident #148 ' s] fall on Friday [May1] at all during that weekend. I go through the 24-hour reports that are generated from the nurse ' s notes and don ' t remember seeing that. Every nurse note is on the report and falls always stand out. The follow up on a fall should occur for 3 days after a fall, even one without an injury. "</p> <p>The Physical Therapy Evaluation and Progress Note dated 5/3/15 indicated the following:</p> <ul style="list-style-type: none"> · Resident #148 was evaluated for a primary diagnosis of weakness. · [Family member #2] reported [resident] was able to walk short distances and go up and down steps with assistance. · During the evaluation, Resident #148 was complaining of " severe pain [left lower extremity] " that was aggravated by movement. · " [Physical therapy evaluation] complete. [Resident #148] unable to stand or [ambulate secondary to complaints of left lower extremity] pain. Nursing reports [resident] had a fall 5/1/15 out of bed. Nursing made aware of [complaints of] pain in [left lower extremity and limited mobility secondary to pain.] <p>Nurse #2 ' s note on Monday 5/4/15 indicated Resident #148 was complaining of left hip pain and left leg pain, the physician was notified, and orders were given to send the resident to Granville Medical Center Emergency Department.</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>The note further indicated [Family member #2] was at his bedside, his left knee was swollen and was slightly turned outward. Review of the Emergency Department (ED) notes dated 5/4/15 revealed:</p> <ul style="list-style-type: none"> · Resident #148 was uncomfortable with any manipulation of either extremity, his left foot was slightly externally rotated and was very stiff. Resistant #148 was resistive to movement of his left leg. · Resident #148 had a left hip fracture and the note further stated, " Labs are also notable for a hemoglobin drop from 10 to 8. The trauma/leg fracture could account for this. " · " Patient discharged from hospital on 5/1/15 to nursing home. Apparently fell down in the nursing home and he was having pain in left hip. Presented to ED. Was found to have left hip fracture. Admitted to hospital for further [evaluation] and management. Impression - acute left hip fracture secondary to fall at nursing home. Consulting orthopedics for possible surgery tomorrow. Acute worsening of chronic anemia. Hemoglobin has dropped to 8 from 10.5 4 or 5 days ago. Ordering a cross match and he will likely need a transfusion. " <p>Review of the Consult report dated 5/5/15 stated, "[Patient] admitted on 5/4/15 through ED for increasing left hip and leg pain. Nursing staff at Brantwood stated he fell on Friday 5/1/15. He had increasing pain over the course of the weekend and was brought to ED. X-rays taken through the ED demonstrated femoral neck fracture. The patient with dementia with limited historical input on questioning. No verbal response to direct questioning today. He does localize pain to the left hip with palpation and with any attempt at passive hip rotation. He does demonstrate pain withdrawal response. His left</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>leg appears shorter than his right but with essentially neutral alignment. Anterior/posterior pelvis xray of left hip demonstrates a displaced angulated femoral neck fracture.</p> <p>Review of the Operative report dated 5/5/15 revealed Resident #148 had a left femoral neck fracture that was repaired by a left hip hemiarthroplasty (an operation to treat a fractured hip that replaces the femoral head - the ball part of the hip).</p> <p>During an interview on 5/20/15 at 11:38 am with the Director of Nursing (DON) when asked about the resident ' s fall and any fall investigation she stated, " I knew to do an investigation and talked to [Nurse #1]. There was a lapse on him falling on Friday to going out Monday. He was able to move without grimacing and didn ' t have external rotation. His wife never said he was in pain. Monday it was reported he was complaining of pain. " When asked about monitoring after an unwitnessed fall to included documentation, neuro checks, and orthostatic blood pressures she stated, " There is a period of monitoring the nurses will do. I have to check how often they are done. We rely on family members to guide and give us insight with the residents, especially the new admissions. "</p> <p>During an interview with the Administrator on 5/20/15 at 3:40 pm she stated, " [Resident #148] arrived at approximately 3:30 pm on Friday May 1st. If we suspect [a resident] fell unwitnessed and hit their head we would do neuro checks. From what I read in the nurse note, there was no indication that he hit his head. I do have an issue that report was not given. " The Administrator indicated she expected the nurse who was caring for the resident to have informed the nurse who took over his care of the fall and to tell the supervisor on duty. She further indicated there</p>	F 157			

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F 157	Continued From page 10 were no fax confirmations of notification to the physician and the expectation is that Nurse #1 should have ensured the physician was notified of the fall as soon as possible after the fall. During an interview on 5/20/15 at 3:43 pm with the Director of Nursing (DON), when asked about what assessment and interventions should be done for a resident after a fall, she stated, " Anytime there is a fall to the head or head injury or if we suspect head injury we would do neuro checks. Another resident across the hall saw [Resident #148 ' s fall] to say he did not hit his head. You use your judgment. If there is something that is going on with the resident then you should call the physician. We may fax. Initially we put the bed in low position and we increase monitoring, but no alarms or mats. A body alarm was placed on him. I don ' t know when. " The DON indicated there was a charge nurse on duty at the facility the night of Resident #148 ' s fall and Nurse #1 should have informed the charge nurse of the fall. During an interview with Physician #1 on 5/22/15 at 12:00 pm, when asked about the notification she received of Resident #148 ' s fall on 5/1/15, she stated, " [Facility staff] told me they sent a fax. I was notified on Monday when [Nurse #2] called and said he was in a lot of pain. I sent him to the ED. I have told them to not fax - to call. I saw [Resident #148] for the admission but [the fall] happened after I saw him. Most of the time [the facility] calls with falls, but they said they were following protocol. They know the office is closed [on evenings and weekends]. They know better. I do not have Saturday office hours. If they had called, I would have asked them questions about Resident #148 ' s assessment, whether or not there were problems with his range of motion, ability to stand, then made a	F 157			

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F 157	Continued From page 11 decision about his care. I keep my beeper on me and I am on call 24/7 for my patients. " During an interview on 5/22/15 at 1:30 pm with Family Member #4, he indicated he visited Resident #148 on Saturday, May 2, 2015, that rehab therapy came in the room to work with Resident #148 and stated, " When they tried to move him he yelled out with every attempt. " He further indicated he informed the rehab therapist that Resident #148 had a fall on 5/1/15 and therapy stated they ' were not aware of any fall. '	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with residents and staff, the facility failed to assist a totally dependent resident out of bed to maintain dignity for 1 of 2 sampled residents (Resident #98). Findings included: Resident #98 was admitted to the facility on 11/1/14 with diagnoses that included quadriplegia. The Minimum Data Set (MDS) dated 2/21/15 indicated Resident #98 was cognitively intact, did not reject care, was totally dependent with bed mobility and transfer, and had a diagnosis of quadriplegia.	F 241	Resident #98 will be out of bed daily unless Resident #98 refuses or there are extenuating circumstances. The Clinical Nurse Manager or designee will monitor daily to ensure compliance for 3 months. Any instances of non-compliance will be reported to the QA/QI committee for follow-up. To ensure the deficient practice does not occur with other residents, all residents should be out of bed at least three times per week or more often if they choose. It will be communicated to all staff that residents should be out of bed at least 3 times per week or as often as the resident	6/23/15	

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F 241	<p>Continued From page 12</p> <p>During an interview on 5/18/15 at 3:30 pm Resident #98 was in bed in a semi-fowler ' s position. When asked if staff treated him with dignity and respect, Resident #98 stated, " I have been laying right here for a week. Sometimes I just want to get up, sit up, not go anywhere - but just sit instead of laying down. I ask [staff] to get me up, but at breakfast they say ' just wait til after breakfast ' , they say the same for anytime of the day. There is always a reason they won ' t get you out of bed. I can ' t even remember how long it has been since I just got out of bed to sit. I did ask several times. " The resident indicated he felt the nurse aides were " too busy to do things that take more time like help me up " because of the low number of nurse aides who work at the facility and the extensive needs of many of the residents.</p> <p>On 5/18/15 at 5:10 pm Resident #98 was observed in bed, in a semi-fowler ' s position.</p> <p>On 5/19/15 at 12:00 pm Resident #98 was not in his room. At 3:30 pm, Resident #98 was observed sitting in his wheelchair in his room, smiling, and watching his television. He stated "I ' ve been laying in bed for 4 weeks, but today I have been up since 11 this morning. I didn ' t get up at all yesterday. My [family member] was here today and asked for [staff] to get me up. They did. [My family member and I] went outside for a while and sat out at the bench. It feels so much better to be out of that bed. It ' ll drive you crazy just laying there all the time. That bed will kill you."</p> <p>On 5/20/15 at 10:30am and 2:40 pm Resident #98 was observed in bed, in a semi-fowler ' s position.</p>	F 241	<p>chooses. The hall nurses will document daily each resident's decision to get out of bed. The Clinical Nurse Manager or designee will monitor daily for compliance. Any instances of non-compliance will be reported to the QA/QI committee for follow-up. Monitoring will continue for a minimum of 3 months.</p>		

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

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FORM APPROVED
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F 241	Continued From page 13 During an interview with the administrator on 5/21/15 at 12:15 pm she indicated oriented residents who request to get out of bed should be assisted out of bed and that she was not aware Resident #98 was not receiving the assistance he needed. On 5/21/15 at 5:00 pm Resident #98 was observed sitting in his wheelchair in his room, watching television. When asked about his day he indicated he had been able to go home for a visit and spend time with his family. He stated, "It would be nice to be able to get up in my chair [everyday], listen to the birds, watch traffic outside, that type of thing." During an interview with Nurse Aide (NA) #8 on 5/22/15 at 12:45 pm she indicated residents are occasionally left in bed and stated, " Because sometimes it is so busy that we don ' t have time to get them up and it is easier to give them care in the bed when you don ' t have time and there are not enough people working. " During an interview with NA #7 on 5/22/15 at 12:50 pm she indicated she was routinely assigned to Resident #98. When asked if there were times Resident #98 requested to get out of bed but was not assisted out of bed, she stated, " I love my patients but sometimes it is so busy and we are so short staffed that we can ' t get everybody up. I have known him to stay in bed and not be able to get up when he asked just because so many other people needed things too. This hall is all long-term and [the residents] need help with everything. "	F 241			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278			6/23/15

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F 278	<p>Continued From page 14</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately assess and include the active diagnoses of Depression and/or Psychosis for the use of psychotropic medications identified in the facility comprehensive assessment tool, the Minimum Data Set (MDS), for 3 of 5 sampled residents (Resident #33, #48 and #132) reviewed</p>	F 278	<p>For Resident #48, Behavioral Health Consultation notes signed by MD for 2/19/15, included diagnoses of dementia unspecified with behavioral disturbances. A diagnosis was added by the MD for depression. On 6/12/15, a corrected MDS was accepted by CMS to reflect the active</p>		

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F 278	<p>Continued From page 15 for unnecessary medications.</p> <p>The findings included:</p> <p>1) Resident #48 was re-admitted to the facility on 1/17/14 from a hospital with cumulative diagnoses which included depression and psychotic disorder with delusions.</p> <p>Resident #48 ' s quarterly Minimum Data Set (MDS) assessment (Section I) dated 4/4/15 did not indicate the resident had an active diagnosis of psychosis or depression. Section N of the MDS indicated the resident received an antipsychotic medication and an antidepressant medication on each of the previous 7 days (7 out of 7 days).</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. Upon inquiry, Nurse #7 reported she completed or reviewed Sections I and N on the 4/4/15 MDS assessment. She noted that the MDS Coordinator, who served as the Interim Director of Nursing (DON), also reviewed Sections I and N of the MDS. During the interview, Nurse #7 acknowledged Section I of the Resident #48 ' s MDS did not include depression or psychosis as an active diagnosis; Section N indicated the resident received an antipsychotic medication and an antidepressant medication on each of the 7 days during the look back period. She stated the diagnosis of depression should have been included as an active diagnosis for Resident #48, but was uncertain as to whether or not the diagnosis of psychosis should have been checked for this resident.</p>	F 278	<p>diagnoses of dementia unspecified with behavioral disturbances and depression.</p> <p>For Resident #33, a diagnosis of depression was listed on the medication administration sheet signed by MD. On 6/12/15, a corrected MDS was accepted by CMS to reflect an active diagnosis of depression.</p> <p>For Resident #132, a discharge summary, dated 2/21/15 and signed by the MD, listed an active diagnosis of depression. On 6/12/15, a corrected MDS was accepted by CMS to reflect an active diagnosis of depression.</p> <p>To ensure the deficient practice is corrected for current residents, a report was obtained from Neil Medical Group for all residents receiving psychotropic medications. For any resident receiving a psychotropic medication without a corresponding active diagnosis listed on the MDS, the MDS nurse will submit a corrected MDS to reflect the active diagnoses.</p> <p>To ensure the deficient practice does not occur for other residents, for any resident on a psychotropic medication, the MDS will reflect an active diagnosis for each medication. A list of all residents receiving psychotropic medications will be obtained from pharmacy each month. The MDS nurse will ensure there is a corresponding diagnosis for each psychotropic medication given. A random sampling (from the psychotropic medication list</p>		

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F 278	<p>Continued From page 16</p> <p>An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim DON. Upon review of Resident #48 ' s quarterly MDS assessment dated 4/4/15, the DON reported both depression and psychosis should have been included as active diagnoses for this resident. The DON indicated if depression and psychosis were not checked in Section I of the MDS as active diagnoses, "Then it ' s an error ...it was missed. " She indicated that her expectation was for information to be coded accurately on the MDS.</p> <p>2) Resident #33 was admitted to the facility on 7/25/14 from a hospital with cumulative diagnoses which included depression.</p> <p>Resident #33 ' s quarterly Minimum Data Set (MDS) assessment (Section I) dated 3/7/15 did not indicate the resident had an active diagnosis of depression. Section N of the MDS indicated the resident received an antidepressant medication on each of the previous 7 days (7 out of 7 days).</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. Upon inquiry, Nurse #7 reported she completed or reviewed Sections I and N on the 3/7/15 MDS assessment. She noted that the MDS Coordinator, who served as the Interim Director of Nursing (DON), also reviewed Sections I and N of the MDS. During the interview, Nurse #7 acknowledged Section I of Resident #33 ' s MDS did not include depression as an active diagnosis; Section N indicated the resident received an antidepressant medication on each of the 7 days during the look back</p>	F 278	obtained from pharmacy) of at least five MDS's will be reviewed by the QA/QI committee monthly for a minimum of 6 months. Any non-compliance will require follow-up action.		

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F 278	<p>Continued From page 17</p> <p>period. She stated the diagnosis of depression should have been included in the MDS assessment for Resident #33.</p> <p>An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim DON. Upon review of Resident #33 ' s quarterly MDS assessment dated 3/7/15, the DON reported depression should have been included as an active diagnosis for this resident. She indicated that her expectation was for information to be coded accurately on the MDS.</p> <p>3) Resident #132 was admitted to the facility on 2/27/15 from a hospital with cumulative diagnoses which included depression.</p> <p>Resident #132 ' s admission Minimum Data Set (MDS) assessment (Section I) dated 3/6/15 did not indicate the resident had an active diagnosis of depression. Section N of the MDS indicated the resident received an antidepressant medication on each of the previous 7 days (7 out of 7 days).</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. Upon inquiry, Nurse #7 reported she completed or reviewed Sections I and N on the 3/6/15 MDS assessment. She noted that the MDS Coordinator, who served as the Interim Director of Nursing (DON), also reviewed Sections I and N of the MDS. During the interview, Nurse #7 acknowledged Section I of Resident #132 ' s MDS did not include depression as an active diagnosis; Section N indicated the resident received an antidepressant medication on each of the 7 days during the look back</p>	F 278			

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F 278	Continued From page 18 period. She stated the diagnosis of depression should have been included in the MDS assessment for Resident #132. An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim DON. Upon review of Resident #132 ' s admission MDS assessment dated 3/6/15, the DON reported depression should have been included as an active diagnosis for this resident. She indicated that her expectation was for information to be coded accurately on the MDS.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		6/23/15	

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F 279	<p>Continued From page 19</p> <p>by: Based on medical record review and staff interviews, the facility failed to develop a care plan to address the topic of falls for 2 of 3 sampled residents (Resident #48 and Resident #33) reviewed for accidents; and, failed to address the use of splints in the care plan for 1 of 1 residents reviewed with a contracture (Resident #7).</p> <p>The findings included:</p> <p>1) Resident #48 was re-admitted to the facility on 1/7/15 with diagnoses including dementia.</p> <p>A review of the resident's Care Area Assessment (CAA) dated 7/1/14 revealed Resident #48 was determined to be at risk for falls due to extreme weakness. The CAA Summary dated 7/1/14 indicated a decision was made to address the topic of falls in the resident ' s care plan.</p> <p>Resident #48 ' s current care plan was initiated on 10/8/14. The care plan did not include a focus area for Falls.</p> <p>A review of Resident #48 ' s medical record revealed the resident had multiple falls on the following dates: 12/18/14, 1/9/15, 2/1/15, 2/15/15, and 2/16/15.</p> <p>Resident #48 ' s current care plan was reviewed by facility staff on 2/25/15. The topic of Falls was not addressed as a focus area on the resident ' s care plan.</p> <p>Resident #48 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 4/4/15 indicated she had moderately impaired cognitive</p>	F 279	<p>For Residents #48 and #33, care plans were updated to reflect falls risk and interventions in place as of 5/27/15. Resident #7's care plan updated, 5/27/15, to reflect the daily placement of a palm protector/finger separator splint.</p> <p>To ensure the deficient practice does not reoccur for residents #48 and #33 or occur with other residents, all falls will be reviewed at the QAQI meeting and a review will be made to ensure that a care plan is in place for anyone who has had a fall. This process to continue for 6 months or longer if needed to ensure compliance. To ensure the deficient practice does not reoccur for resident #7 or occur for other residents, for devices ordered by rehab, a rehab notification will be given to the MDS Nurse to ensure that a care plan is in place for anyone who has a new device. The DON will also receive notification of new Rehab devices for review at the QAQI meeting to ensure that a care plan is in place for anyone who has a new device. Any non-compliance will be corrected immediately. This process to continue for 6 months or longer if needed to ensure compliance.</p> <p>To ensure the deficient practice does not occur for all residents, for all current residents who sustained a fall in the last 60 days the care plan will be reviewed by the MDS nurse or DON and a care plan will be implemented. The QAQI committee will review weekly all care plans for any resident having a fall to</p>		

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F 279	<p>Continued From page 20</p> <p>skills for daily decision making. No behaviors nor rejection of care were noted. The resident required limited assistance for all of her Activities of Daily Living (ADLs) with the exception of requiring extensive assistance for dressing and toileting; and supervision only for locomotion on the unit. She utilized a walker as a mobility device. Resident #48 was assessed as occasionally incontinent bladder and bowel. The MDS fall history revealed the resident had 2 or more falls without injury since her last assessment. A Fall Risk Assessment dated 4/4/15 revealed Resident #48 was assessed as being at a " High Risk for Falling, " as indicated by a score of 65 (with a high risk determined by a score of 45 and higher).</p> <p>Further review of Resident #48 ' s medical record revealed the resident had additional falls on the following dates: 4/30/15 and 5/10/15.</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. During the interview, the nurse discussed the facility ' s process for the development and revision of care plans related to falls. Nurse #7 indicated she was responsible for updating a resident ' s care plan with any changes made in the interventions implemented after a fall. Upon review of Resident #48 ' s care plan, Nurse #7 acknowledged the topic of Falls was not included in her care plan. When asked if she would have expected to have the topic of Falls to be addressed as a focus area on the care plan for this resident, Nurse #7 stated, " Yes. "</p> <p>An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim Director of Nursing</p>	F 279	<p>ensure a falls care plan is in place. Any non-compliance will have an updated action plan as needed.</p> <p>MDS Nurse counseled 5/20/2015 on the importance of developing care plans for residents who have fallen. MDS nurse responsible for initiating and updating care plans.</p>		

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F 279	<p>Continued From page 21</p> <p>(DON). During the interview, Resident #48 ' s current care plan was reviewed. The DON acknowledged the topic of Falls was not included on her care plan. She reported that if a resident was a fall risk, a fall care plan would need to be put into place. The DON stated her expectation was that every time a resident had a fall, the facility would do an assessment and evaluate fall interventions to be put into place as part of the resident ' s care plan.</p> <p>2) Resident #33 was admitted to the facility on 7/25/14 from a hospital with cumulative diagnoses which included generalized muscle weakness.</p> <p>A review of Resident #33 ' s Care Area Assessment (CAA) dated 9/4/14 revealed the resident was determined to be at risk for falls due to impaired sight, especially with low light. The CAA Summary dated 9/4/14 indicated a decision was made to address the topic of falls in her care plan.</p> <p>Resident #33 ' s current care plan was initiated on 9/10/14. The care plan did not include a focus area for Falls.</p> <p>A review of Resident #33 ' s medical record revealed the resident had a fall on 11/1/14.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment dated 3/7/15 indicated Resident #33 had intact cognitive skills for daily decision making. No behaviors nor rejection of care were noted. The resident required supervision for all of her Activities of Daily Living (ADLs). She utilized a walker as a mobility device. Resident #33 was assessed as</p>	F 279			

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F 279	<p>Continued From page 22</p> <p>occasionally incontinent bladder and always continent of bowel. The MDS fall history revealed she did not have a fall since her last assessment. There was not a fall risk assessment available for review in the resident ' s medical record.</p> <p>A review of Resident #33 ' s medical record revealed the resident had a fall on 5/17/15. Resident #33 ' s current care plan did not include a focus area for falls on the date of the review (5/20/15).</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. During the interview, the nurse discussed the facility ' s process for the development and revision of care plans related to falls. Nurse #7 indicated she was responsible for updating a resident ' s care plan with any changes made in the interventions implemented after a fall. Upon review of Resident #33 ' s care plan, Nurse #7 acknowledged the topic of Falls was not included in her care plan. When asked if she would have expected to have the topic of Falls to be addressed as a focus area on the care plan for this resident, Nurse #7 stated, " Yes. " She indicated that even if a resident had only one fall, the topic of Falls would be included on his/her care plan.</p> <p>An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim Director of Nursing (DON). During the interview, Resident #33 ' s current care plan was reviewed. The DON acknowledged the topic of Falls was not included on her care plan. She reported that if a resident was a fall risk, a fall care plan would need to be put into place. The DON stated her expectation</p>	F 279			

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F 279	Continued From page 23 was that every time a resident had a fall, the facility would do an assessment and evaluate fall interventions to be put into place as part of the resident ' s care plan. 3. Resident #7 was admitted on 1/03/03 with diagnoses including seizure disorder, vascular dementia, Alzheimer disease, left hand contracture and depression. The most recent Minimum Data Set (MDS), dated 3/14/15, revealed the resident was severely cognitively impaired. The resident required extensive assistance with such activities of daily living (ADL) as mobility and eating, total assistance with dressing, bathing and toileting. The Plan of Care for resident #7, dated 3/14/15, indicated that the resident had an ADL performance deficit with all ADL except for eating. There was no information available on the care plan to address the left hand contracture and the use of the palm protector and finger separator. During an interview on 5/21/15 at 3:10PM, the director of nursing (DON)/MDS confirmed the updated care plan dated 12/12/14 did not address the use of splints. She indicated the splint information may have gotten dropped off when the new electronic system was implemented in September 2014. However, she did not present the previous care plan prior to the electronic change over.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		6/19/15	

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F 309	<p>Continued From page 24</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to effectively assess and monitor a resident after a fall from bed, failed to effectively communicate a fall among staff providing care, and failed to recognize pain and for one of four residents (Resident #148) reviewed for accidents. Findings included: Resident #148 was admitted to the facility on Friday, 5/1/15 from a hospital with diagnoses that included generalized weakness, urinary tract infection, diabetes, dementia, acute renal failure and failure to thrive. Record review of Resident #148 ' s Morse Fall Scale completed on 5/1/15 revealed a score of 55 which indicated a " high risk for falling. " Record review of the Admission Screen dated 5/1/15 indicated Resident #148 required extensive assistance with bed mobility and transfer. The Interim Care Plan dated 5/1/15 at 4:30 pm stated Resident #148 " is a fall risk. " The nurse Admission Note written by Nurse #1 on 5/1/15 at 6:58 pm stated Resident #148 " Arrived at this facility at approximately 3:30 pm. Being admitted with generalized weakness, failure to thrive, dementia, [urinary tract infection], [acute renal failure]. Resident is confused. He has a hard time hearing and you have to talk really loud</p>	F 309	<p>For resident #148, who is currently a resident of the facility, his current status is CGA (contact guard assist) to SBA (Stand by assist)for bed mobility. CGA to SBA for all transfers. He is ambulating 120 feet with a rolling walker CGA with verbal cues for posture and encouragement. Resident is able to tolerate out of bed to chair for 3 hours. Resident is currently care planned for staff to anticipate/meet the needs of the resident, keep call light within reach, educate resident/family/caregivers of safety reminders, keep frequently used items within reach, maintain pad alarm placement, and follow the facilities fall protocol.</p> <p>For all current residents who had a fall since May 1, 2015, a review of incident reports, stand up meeting minutes, rehab screen referrals and MDS's was completed by 5:00 PM on May 22, 2015, to ensure any resident identified was assessed after a fall.</p> <p>To ensure the deficient practice does not reoccur for resident #148 or occur for any other residents, compliance with communicating to the next shift and</p>		

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F 309	Continued From page 25 to him. " Review of the Fall Log for May 2015 revealed Resident #148 had an "unwitnessed fall with injury" on 5/1/15. Review of the Fall Scene Investigation Report completed on 5/1/15 by Nurse #1 indicated the following and is quoted in part as noted below: · Resident #148 was alone and unattended at the time of the fall from his bed at 8:40 pm, he was "confused", and stated he "needed to get out and go bake a cake." · The resident's fall occurred "next to transfer surface [bed]." Instructions on the report stated to "assess postural hypotension" (a form of low blood pressure that happens upon standing from sitting or lying down that can result in dizziness or fainting) and "if fall within 5 feet of transfer surface do orthostatic [blood pressure] (blood pressure that is taken while the resident is lying down, then repeated after several minutes with the resident sitting up, then repeated after several minutes again while the resident is standing.)" "Yes" was checked at question asking if vital signs were "out of normal range for this resident" and orthostatic [blood pressures] were not done. There were no vital signs documented anywhere on the form or in the resident's chart until approximately 6 hours after the fall. Review of the nurse notes for Saturday, 5/2/15 - Sunday 5/3/15 revealed Resident #148 was incontinent of bowel and bladder, restless " (moving around in bed some calling out)." The notes further indicated the resident was total care with his activities of daily living and that there were no complaints of pain. There were no nurse's notes until a late-entry note on 5/4/15 about Resident #148 having a fall on 5/1/15. Record review of the Medication Administration Record for 5/1/15-5/4/15 revealed Resident #148	F 309	assessing a resident after a fall will be met by completing an incident report and placing in the Clinical Nurse Manager's box. The incident report form was revised to indicate that the doctor is verbally contacted. The facility has a Clinical Nurse Manager in the building 7 days per week, so by 9:00 AM and several times throughout the day, the Clinical Nurse Manager will review compliance of verbally notifying the physician of falls. With falls, all pertinent information must be placed in the electronic health record and acute charting will occur for 72 hours. Policy H3.1 Acute Episode Monitoring was updated to include guidelines for Neurochecks. The policy indicates the following monitoring time frames and frequency: Falls 3 days, every shift; head injury 3 days, every shift; and Neuro Checks every hour for 4 hours. Standing orders will be updated to include neurological checks to be performed if: *There is a change in mental status *Fall is Unwitnessed *There is a head injury Neurological testing should include evaluation of speech, hand grips, level of consciousness, skin color, PERRLA (pupil equal round react to light accommodation), any changes in behavior and performed every hour for 4 hours. The nurse will notify the Physician if there are any acute changes. If no changes, neuro-checks will be discontinued. An in-service was done on acute charting to ensure staff knows how		

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F 309	Continued From page 26 did not receive any pain medication. The Late Entry nurse note written by Nurse #1 on Monday, 5/4/15 indicated it was an Incident Note for 5/1/15 at 10:00 pm. The late entry incident note stated, " The resident across the hall called out for help. I went to room and [Resident #148] had slid to the floor beside the bed. He stated, ' I screwed up. ' Vitals and assessment were done before the resident was put back to bed. He was assessed more thoroughly after being placed back in bed. There were no scratches, bruises, red areas or anything showing at that time. Also, when palpated at this time there were no facial grimaces or signs of pain. During an interview on 5/20/15 at 3:04 pm with Nurse #1, when asked about the events surrounding Resident #148 ' s fall on 5/1/15, she indicated she was doing the medication pass when the resident across the hall from Resident #148 called out for help because she saw Resident #148 fall out of bed. Nurse #1 stated, " I locked the cart and went to the room. He was sitting beside the bed and said ' I messed up. ' I assessed him on the floor, got vitals and got help to put back in bed. I checked him head to toe. We rolled him over. There were no bruises or obvious injury. He denied hurting. He was in the bed before he was found on the floor. He was sitting on the floor with his back to the bed and the bed was in the lowest position. He rolled over for me during the admission assessment Nurse #1 further stated, " I palpated [Resident #148 ' s] hips and his whole body but there was no indication of pain. Nurse #1 indicated she worked the following day, 5/2/15, but was working on another hall, not with Resident #148. " [Nurse Aide (NA) #3 and NA #4 helped me get him back in bed. I went back in before I left to re-check him. I cannot remember telling the	F 309	to chart acute episodes. Clinical Nurse Manager will monitor for compliance for a minimum of 6 months. Any non-compliance will be reported to the QA/QI Committee to determine follow-up action/plan. Staff training was complete by May 27, 2015. Nurses were in-serviced on the following when a fall occurs: *A head to toe assessment will be completed *Resident vitals will be taken *SBAR will be completed *Alert will be sent through the electronic reporting system to notify staff that a resident has fallen *Physician will be notified verbally. FAXES WILL NO LONGER BE PERMISSIBLE *Telephone order will be completed *Nurse taking the order will sign the telephone order sheet *A separate nurse will verify the telephone order *An incident report will be completed *Charge nurse must notify on-call *On-call nurse to be notified within 30 minutes *Review of Acute Charting Policy which includes neurological testing CNAs were in-serviced: *On what the nurses are responsible for related to falls		

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F 309	Continued From page 27 nurse I gave report to, Nurse #5, about the fall. I can ' t remember if I did or I didn ' t. I did not report it to anyone that night. The report was put in the Director of Nursing (DON) box when I left. She had it Monday morning when I came back in. I am not aware that I am supposed to let the DON know or call the doctor if there is no injury. " During an interview on 5/21/15 at 1:13 pm with NA #3 she indicated she assisted Resident #148 back to bed on 5/1/15 after his fall. She further indicated he showed no indication of pain that she could recall, but " he kept asking for his wife. " During an interview on 5/21/15 at 3:22 pm with NA #4 she indicated she assisted Resident #148 back to bed on 5/1/15 after his fall and stated, " He didn ' t seem to be hurt. I changed him later and he was swinging his arms some so I asked someone to come help me because he is such a tall man. " During an interview with Nurse #6 on 5/22/15 at 3:15 pm she indicated she worked night shift on 5/1/15 and stated, " I came in at midnight that night and worked until 7 am. At the beginning of my shift about 1 am when the aide was doing her rounds she told me (Resident #148) was restless. I checked on him and he was restless but did not seem to be in pain, no moaning. He slept the rest of the night. I got report from [Nurse #5]. She did not tell me anything about him falling. If I had known that he had fallen then I would have looked at him even more thoroughly through the night. " She indicated there were no nurse ' s notes when she worked that night about Resident #148 having a fall on 5/1/15. During an interview on 5/19/15 at 1:45 pm with Family Member #2 she indicated she and Family Member #4 were at the facility and visited Resident #148 over the weekend. Family member #2 stated, " [Resident #148] wasn ' t	F 309	*Relaying information on falls to the nurse Nurse #1 was in serviced on May 21, 2015.		

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F 309	Continued From page 28 talking much over the weekend but had his hand on his [left] leg. On Monday I came in, tried to move his left leg over and he yelled out. I told the nurse I knew something was wrong. I said ' I know this man. ' I asked the head nurse, the director or something, about a written report about his fall. She said the nurse that was on duty had not written up anything. That was Monday. " During an interview with Nurse #2 on 5/21/15 at 9:30 am she indicated she was the first-shift nurse assigned to Resident #148 on 5/2/15-5/4/15. She stated, " I didn ' t know he had fallen on Friday. On Sunday his wife told me he had fallen when he came in Friday. The rehab therapist on Sunday said he could not stand him up because [his left leg was hurting]. That was when we were changing shifts about 3pm. The resident never seemed to be hurting to me that weekend. " Nurse #2 indicated Resident #148 did not appear to be in pain on Saturday, May 2nd and Sunday, May 3rd. She further stated, " He was new and report was he was non-ambulatory so we did not try to get him up that weekend. We would usually wait to get [a new admission resident] up until rehab evaluates to see what they need. I could never find the transfer assessment in the computer. His [Family Member #2] was talking about his pain that Sunday morning and said, ' He says he hurts. ' When I asked him he never said he was hurting. Nobody reported any pain to me during his care. I could not find a note or anything about a fall from Friday. I looked at the nurse ' s notes but there wasn ' t one about a fall. He seemed to be in more pain Monday than on Sunday. " Nurse #2 indicated when there is a fall the nurse should notify the doctor, the family member, make a nurse ' s note in the computer, and complete the fall report by the end of the shift.	F 309			

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F 309	<p>Continued From page 29</p> <p>During an interview with Nurse Aide (NA) #1 on 5/20/15 at 1:49 pm she stated, " I worked with [Resident #148] on Saturday (5/2/15) first shift. [Family member #2] was here that morning and a male relative was here in the afternoon. [Resident #148] was incontinent of bowel and bladder. I was giving him his bath and turned him to the left side. He said, ' I hurt so bad ' and was holding his left leg. I told him I would let the nurse know. I told her. It was [Nurse #2]. It was in the morning when I was doing my baths, but I don ' t remember exactly what time. "</p> <p>During an interview with NA #2 on 5/20/15 at 2:00 pm she indicated she worked on Sunday, 5/3/15, first shift with Resident #148. She stated, " In the morning I was trying to wash his feet and legs. He tried to go for his left leg like he was trying to keep me from moving him. [Family member #2] was here and told me he had a fall that Friday. I reported it to Nurse #2 and I went to the supervisor (Nurse #3). I let her know about his fall. Nurse #3 said she did not know about the fall, then Nurse #3 and Nurse #2 talked to each other. He still was hurting on Monday. " The aide indicated that the resident ' s reaction on Sunday was of obvious pain with any movement of his left leg.</p> <p>During an interview on 5/21/15 at 10:22 am with Nurse #3 she indicated she was the weekend nurse supervisor who worked on 5/2/15-5/3/15 and stated, " I work every other weekend. I don ' t recall knowing about [Resident #148 ' s] fall on Friday [May1] at all during that weekend. I go through the 24-hour reports that are generated from the nurse ' s notes and don ' t remember seeing that. Every nurse note is on the report and falls always stand out. The follow up on a fall should occur for 3 days after a fall, even one without an injury. "</p>	F 309			

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F 309	<p>Continued From page 30</p> <p>The Physical Therapy Evaluation and Progress Note dated 5/3/15 indicated the following:</p> <ul style="list-style-type: none"> · Resident #148 was evaluated for a primary diagnosis of weakness. · [Family member #2] reported [resident] was able to walk short distances and go up and down steps with assistance. · During the evaluation, Resident #148 was complaining of " severe pain [left lower extremity] " that was aggravated by movement. · " [Physical therapy evaluation] complete. [Resident #148] unable to stand or [ambulate secondary to complaints of left lower extremity] pain. Nursing reports [resident] had a fall 5/1/15 out of bed. Nursing made aware of [complaints of] pain in [left lower extremity and limited mobility secondary to pain.] <p>Nurse #2 ' s note on Monday 5/4/15 indicated Resident #148 was complaining of left hip pain and left leg pain, the physician was notified, and orders were given to send the resident to the Emergency Department. The note further indicated [Family member #2] was at his bedside, his left knee was swollen and was slightly turned outward.</p> <p>Resident #148 ' s Discharge Minimum Data Set (MDS) dated 5/4/15 indicated the following:</p> <ul style="list-style-type: none"> · He had impaired hearing and vision, had clear speech, made himself understood and understood others. · He needed extensive assistance of one person for bed mobility, and transfer did not occur from his admission on 5/1/15 to his discharge on 5/4/15. · He did not have pain and did not receive any pain medication during his admission. · He did not have any falls one month prior to his admission and had no fractures related to any falls for 6 months prior to admission. 	F 309			

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F 309	<p>Continued From page 31</p> <ul style="list-style-type: none"> · He had a fall during his admission from 5/1/15-5/4/15. <p>Review of the Emergency Department (ED) notes dated 5/4/15 revealed:</p> <ul style="list-style-type: none"> · Resident #148 was uncomfortable with any manipulation of either extremity, his left foot was slightly externally rotated and was very stiff. Resistant #148 was resistive to movement of his left leg. · Resident #148 had a left hip fracture and the note further stated, " Labs (dated 5/4/15) are also notable for a hemoglobin drop from 10 to 8. The trauma/leg fracture could account for this. " · " Patient discharged from hospital on 5/1/15 to nursing home. Apparently fell down in the nursing home and he was having pain in left hip. Presented to ED. Was found to have left hip fracture. Admitted to hospital for further [evaluation] and management. Impression - acute left hip fracture secondary to fall at nursing home. Consulting orthopedics for possible surgery tomorrow. Acute worsening of chronic anemia. Hemoglobin has dropped to 8 from 10.5 4 or 5 days ago. Ordering a cross match and he will likely need a transfusion. " <p>Review of the Operative report dated 5/5/15 revealed Resident #148 had a left femoral neck fracture that was repaired by a left hip hemiarthroplasty (an operation to treat a fractured hip that replaces the femoral head - the ball part of the hip).</p> <p>During an interview on 5/20/15 at 11:38 am with the Director of Nursing (DON) when asked about the resident ' s fall and any fall investigation she stated, " I knew to do an investigation and talked to [Nurse #1]. There was a lapse on him falling on Friday to going out Monday. He was able to move without grimacing and didn ' t have external rotation. His wife never said he was in pain.</p>	F 309			

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F 309	<p>Continued From page 32</p> <p>Monday it was reported he was complaining of pain. " When asked about monitoring after an unwitnessed fall to included documentation and orthostatic blood pressures she stated, " There is a period of monitoring the nurses will do. I have to check how often they are done. We rely on family members to guide and give us insight with the residents, especially the new admissions. " During an interview with the Administrator on 5/20/15 at 3:40 pm she stated, " [Resident #148] arrived at approximately 3:30 pm on Friday May 1st. I do have an issue that report was not given. " The Administrator indicated she expected the nurse who was caring for the resident to have informed the nurse who took over his care of the fall and to tell the supervisor on duty. During an interview on 5/20/15 at 4:26 pm with the Administrator she stated a 72-hour report (summary) is printed Monday morning, the information on the report is triggered by the nurses when notes are written in the electronic medical record, every nurse note written in the 72-hour time frame is on the report, and the report is reviewed by administration on Monday during the stand-up meeting. She further stated the report is used as a means of communication and is the same information that is on the 24-hour report generated every weekend day morning by the weekend supervisor. Record Review of the " 72 Hour Summary " , that was dated 5/1/15-5/4/15 and printed on 5/4/15 at 7:35 am, indicated there were no nurse ' s notes regarding Resident #148 ' s fall on 5/1/15. During an interview on 5/20/15 at 3:43 pm with the Director of Nursing (DON) she indicated there was a charge nurse on duty at the facility the night of Resident #148 ' s fall and Nurse #1 should have informed the charge nurse of the fall. During an interview on 5/21/15 at 11:08 am with</p>	F 309			

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F 309	Continued From page 33 the DON, she produced an undated document titled " Acute Episode Monitoring " and stated, " When there are issues that happen they have to follow those guidelines. They are at every nurse ' s station in the red book. " The Acute Episode Monitoring guide, in part, indicated the following: · After a fall, for 3 days, there should be monitoring every shift of the consequences of the fall, pain, shortening/external rotation of the extremity, interventions, and vitals done. · A new admit, for 7 days, there should be monitoring every shift of vitals, pain, alertness, orientation, any complaints, and anything out of the ordinary. During an interview on 5/22/15 at 1:30 pm with Family Member #4, he indicated he visited Resident #148 on Saturday, May 2, 2015, that rehab therapy came in the room to work with Resident #148 and stated, " When they tried to move him he yelled out with every attempt. " He further indicated he informed the rehab therapist that Resident #148 had a fall on 5/1/15 and therapy stated they ' were not aware of any fall. '	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, records review and staff	F 318	To ensure resident #7 is wearing the	6/19/15	

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F 318	<p>Continued From page 34</p> <p>interviews, the facility failed to apply the splint for left hand contracture on 1 of 1 resident (Resident #7)</p> <p>Findings included:</p> <p>Resident #7 was admitted on 1/03/03 with diagnoses including seizure disorder, vascular dementia, Alzheimer disease, left hand contracture and depression. The most recent Minimum Data Set (MDS), dated 3/14/15, revealed the resident was severely cognitively impaired. The resident required extensive assistance with such activities of daily living (ADL) as mobility and eating, total assistance with dressing, bathing and toileting.</p> <p>The Plan of Care for resident #7, dated 3/14/15, indicated that the resident had an ADL performance deficit with all ADL except for eating. There was no information available on the care plan to address the left hand contracture and the use of the palm protector and finger separator.</p> <p>Review of the physician ' s order dated 6/15/12, revealed Resident #7 to wear splint daily during the day and removed at night. There were no discontinued orders.</p> <p>Review of occupational evaluation on 5/21/12, revealed the resident was referred to occupational therapy to re-establish the wearing of left hand palm protector/finger separator. The splint was to be worn during the day and off at night to prevent skin breakdown. There was</p> <p>During an observation on 5/19/15 at 4:08PM, Resident #7 was lying in bed and a beige palm protector/finger separator splint was lying on night</p>	F 318	<p>palm protector/finger separator splint as ordered by the physician, the hall nurse will monitor, daily for 3 months or longer if needed to resolve the deficient practice. Any non-compliance will be reported by the nurse to the Clinical Nurse Manager who will report to the QA/QI Committee for follow-up as needed.</p> <p>To ensure the deficient practice does not occur with other residents, the hall nurse will monitor any resident with an MD order to wear a splint daily for 3 months or longer if needed to ensure compliance. Any non-compliance will be reported by the nurse to the Clinical Nurse Manager who will report to the QA/QI Committee for follow-up as needed.</p>		

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F 318	<p>Continued From page 35</p> <p>stand. There was an undated sign posted on closet door that read, resident was to wear splints daily, on in morning after morning care and off at night any questions call occupational therapy.</p> <p>During an observation on 5/20/15 at 8:20AM, resident up in bed and left hand splint located in red container on night stand.</p> <p>During an observation on 5/20/15 at 9:20AM, the palm protector/finger separator splint remained in red container on the night stand. Resident #7 was very confused and disoriented as she sat in her wheelchair beside the bed.</p> <p>During an observation on 5/20/15 at 10:51AM, Resident #7 was sitting up in wheelchair and the palm protector/finger separator splint remained in the red container that was located on the night table.</p> <p>During an observation on 5/20/15 at 1:30PM, Resident #7 seated in her wheelchair and the palm protector/finger separator splint remained in the red container on the night stand.</p> <p>During an interview on 5/20/15 at 4:00PM, NA# 5 indicated that the splint should be applied on 1st shift and removed on second shift when the resident was put to bed for the evening. She indicated the sign posted on the closet door stated when the splint should be applied and removed.</p> <p>During a continuous observation on 5/21/15 at 8:15AM to 10:30AM, Resident #7 was seated in wheelchair in her room at 8:15AM. She was taken</p>	F 318			

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F 318	<p>Continued From page 36</p> <p>to the dining room at 8:30AM, without the splint in place, the splint was lying on the bed when Resident #7 went and returned to the dining room. Resident #7 was returned to the room at 9:30AM and placed next to her bed where the splint remained. NA#6 entered the room at 10:00AM to assist the roommate with care. The splint was not applied to Resident #7 until 11:10AM. Resident #7 made no attempt to remove the splint during the observations.</p> <p>During an interview on 5/21/15 at 11:10AM, NA #6 was assigned to Resident #7 during the observations on two different days. The NA confirmed she had not put the splint on Resident #7 on at least one of the days she was assigned to Resident #7. NA#6 further indicated she could not recall whether the resident, nurse or family member had removed the splint at any time when the splint was scheduled to be worn.</p> <p>During an interview on 5/21/15 at 11:15AM, Nurse#4 indicated Resident #7 should wear the palm protector/finger separator daily after the morning care was provided. Nurse #4 indicated she did not remove the splint at any time from Resident #7 ' s hand. The nurse further stated she had been told by staff that the resident removed the splint but there was no documentation to support the removal by the resident. She confirmed that if the resident was removing the splint it should have been reported and a referral to therapy.</p> <p>During an observation on 5/21/15 at 11:20AM, Resident #7 was seated the in wheelchair with splint applied, sitting quietly falling off to sleep, no attempt to remove the splint.</p>	F 318			

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F 318	Continued From page 37 During an interview on 5/21/15 at 12:18PM, the physical therapy assistant(PTA) indicated that the Resident #7 had been wearing splints since 5/21/12. The expectation was for the resident to wear the splint daily in the day time as indicated by the sign posted on resident closet and removed at night when the resident went to bed at night. The PTA indicated that he was unaware that there was a problem with Resident #7 removing the splint or not wearing the splint at this time. During an interview on 5/21/15 at 3:10PM, the director of nursing (DON) indicated the expectation was for staff to apply splint. She acknowledged that there was no documentation of when the splint was applied to Resident #7. She did confirm that the posted sign on resident closet indicated the splint should be applied after AM care and removed when resident was placed to bed. The DON added she was unaware of Resident #7 being able to remove the splint. She also confirmed the updated care plan dated 12/12/14 did not address the use of splints. She indicated that the splint information may have gotten dropped off when the new electronic system was implemented in September 2014. However, she did not present the previous care plan prior to the electronic change over.	F 318			
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.	F 323		6/23/15	

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F 323	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain water temperatures within acceptable ranges in 4 (rooms #101, #104, #117 and #201) of 8 resident rooms; and, the facility failed to initiate, update, and implement fall prevention interventions to prevent recurrent falls for 1 of 3 sampled residents reviewed for accidents (Resident #48). The findings included: 1) The facility did not have a policy in place regarding water system monitoring or preventative maintenance. Observation on 5/18/15 at 3:00 PM revealed the water temperature in room #101 coming from the sink felt too hot. Could not leave hand under running hot water for more than 5 seconds after the water heated up. Observation on 5/18/15 at 3:13 PM accompanied by the Maintenance Technician revealed the facility hand held thermometer was calibrated in ice water at 32 degrees for a period of 3 minutes. The Maintenance Technician and surveyor checked the facet water temperatures in the sinks using the calibrated thermometer and the following results were obtained: Room Degrees #101 123 #104 121 #117 120 #201 121	F 323	1) On 5/18/15, the thermostat on the hot water heater was adjusted to correct water temperatures for rooms #101, #104, #117 and #201. A plumber was contacted to ensure mixing valves and thermostats were working properly. Maintenance continued to monitor water temperatures after adjustment was made to ensure temperatures were within acceptable range. To ensure the deficient practice does not reoccur, the policy has been updated for water temperatures to be recorded daily including one resident room per hall plus the shower room. Water temperatures are recorded and kept in the log book at the central energy plant. The maintenance department will take immediate action if the water temperature exceeds +/- 2 degrees the maximum allowable temperature of 116 degrees. Out of range temperatures will be reported to the Director of Plant Operations or designee, noted on the temperature logs and reported to the QA/QI Committee for follow up action if needed. A preventive maintenance work order has been updated to include mixing valve inspections, cartridge cleaning and replacement. 2) For resident #48, daily rounds made by Clinical Nurse Manager to ensure		

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F 323	<p>Continued From page 39</p> <p>Interview on 5/18/15 at 3:10PM with resident #32, who was cognitively intact, revealed the water coming from the sink faucet was hot. Resident #32 reported today was the first day she noticed it.</p> <p>Interview on 5/18/15 at 4:40 PM with resident #145, who was cognitively intact, revealed the water temperature got hotter the longer it ran. She always thought it was hot wasn't sure if she noticed any difference since her admission. Resident #145 was admitted on 4/21/15.</p> <p>Interview on 5/18/15 at 4:36 PM with NA #9 revealed she had not noticed water being hot. She did not run the water that long so she did not notice it. If she had noticed it, she would have turned it off and reported it to her nurse and recorded it on a maintenance slip.</p> <p>Interview on 5/18/15 at 4:43 PM with NA #10 revealed she had not noticed the water being too hot. If she had noticed the water being too hot, she would have reported to her hall nurse and recorded it in the Care Tracker system. Then she would have called the Maintenance Technician.</p> <p>Review of water temperature logs from February 2, 2015 through April 12, 2015 revealed water temperatures were within the range of 109 degrees F and 115 degrees F.</p> <p>Interview on 5/18/15 at 5:50 PM with the Maintenance Technician revealed the water temperature logs from April 13, 2015 to May 15, 2015 were located in a box that he threw out on May 15, 2015.</p> <p>Interview on 5/18/15 at 3:20 PM with the</p>	F 323	<p>interventions listed on the care plan were in place. NA's (nursing assistants) will be in-serviced 6/16/15 and 6/18/15 on how to access the resident's care plan in the electronic health record. The MDS nurse will be responsible for the initiation and revision of care plans to ensure interventions are up to date. The MDS Coordinator or designee will ensure interventions are implemented within 24 hours. Any updated interventions will be printed and placed at the nurses station for easier NA and nurse access to information.</p> <p>To ensure the deficient practice did not occur for other residents in the facility, for all current residents who sustained a fall in the last 60 days the care plan will be reviewed by the MDS nurse or DON. NA's were in-serviced on 6/16/15 and 6/18/15 on accessing care plans and the kardex in the electronic health record.</p> <p>The MDS nurse will be responsible for the initiation and revision of care plans to ensure interventions are up to date. The MDS Coordinator or designee will ensure interventions are implemented within 24 hours. Any updated interventions will be printed and placed at the nurses station for easier NA and nurse access to information. The QA/QI committee will review all care plans for any resident having a fall. Any non-compliance will have an updated action plan as needed.</p> <p>The Clinical Nurse Manager or designee will randomly select 3 NA's per week to</p>		

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F 323	<p>Continued From page 40</p> <p>Maintenance Technician revealed the water for the 100 hall came from 2 of the 4 water heaters, ran through the mixing valve which regulates the water temperature and then was dispersed to the 100 and 400 hall resident rooms. The water which is not dispersed to the resident rooms returns through the hot water return lines and mixes with the water in the mixing valve. The Maintenance Technician could not clarify which temperature gauge on the mixer was for the 100 hall water temperature and which gauge was for the 400 hall water temperature.</p> <p>Observation on 5/18/15 at 4:03 PM of the hot water heaters that supplied the 100 hall and 400 halls revealed the temperature gauges were reading 123 degrees Fahrenheit (F) and 122 degrees F. The mixer temperature gauge for the water coming in to the mixer read 128 degrees F and the two gauges for the water going out to the 100 hall and 400 hall read 126 degrees F and 120 degrees F.</p> <p>Interview on 5/18/15 at 4:20 PM with the Maintenance Technician revealed there were no reported problems with the water temperature being elevated by the residents or the staff. When a problem was reported, he adjusted the hot water heater accordingly and it would resolve the issue. He revealed that the last reported problem was around January or February. The water was too cold and he had to adjust the water heater temperature up higher. He did not record the adjustment date and time or pre and post water temperature readings. He normally made seasonal adjustments to the water heaters and periodical adjustments to the mixing valve. The mixing valve cartridge is removed so it can be cleaned in a vinegar solution every 5 to 6 months</p>	F 323	demonstrate how to access care plans for a period of 3 months. Any NA unable to demonstrate how to access will be retrained and required to demonstrate the ability to access the care plan. Non-compliance will be reported to the QA/QI committee.		

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F 323	<p>Continued From page 41</p> <p>and a replacement cartridge is inserted. The facility had a total of 5 hot water heaters and the last major issue they had was approximately 6 months ago when one of the hot water heaters was replaced. The Maintenance Technician reported the water temperatures are checked daily in one resident room on each hall and in the shower room. If there was a problem reported with the water system that he could not fix, then he called a plumber. He notified the Director of Plant Operations when-ever a problem was reported to him.</p> <p>Interview on 5/18/15 at 3:45 PM with the Director of Plant Operations revealed no elevated water temperature issue had been reported to her. She would expect the Maintenance Technician to report any issues with the water system to her and she in turn reports any issues to the Senior Administrator. When problems were reported to her, she consulted with the maintenance technician and determined if it could be fixed internally or if a plumber needed to be called.</p> <p>Interview on 5/18/15 at 4:55 PM with the Administrator revealed she was not aware of the elevated water temperatures and she expected the Maintenance Technician to report to his supervisor if there were any problems with the water temperatures.</p> <p>Interview on 5/18/15 at 6:00 PM with the plumber from a local Plumbing company revealed he turned the hot water heaters down to 120 degrees F at 5:20 PM.</p> <p>Review of water temperature log dated 5/18/15 at 6:30 PM revealed the water temperature in various rooms on the 100 hall and room #201</p>	F 323			

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F 323	<p>Continued From page 42 were as follows:</p> <table border="0"> <tr> <td>Room</td> <td>Degrees F</td> </tr> <tr> <td>#101</td> <td>110</td> </tr> <tr> <td>#103</td> <td>110</td> </tr> <tr> <td>#109</td> <td>111</td> </tr> <tr> <td>#201</td> <td>111</td> </tr> </table> <p>Review of water temperature logs for 5/19/15, 5/20/15, and 5/21/15 revealed the water temperature, from one resident room on each hall and the shower, was documented every 1 to 3 hours from 7:15 AM to 5:30 PM and ranged from 110 degrees F to 114 degrees F. Water temperature readings were not obtained during any other time from 5/15/15 to 5/21/15.</p> <p>2) Resident #48 was re-admitted to the facility on 1/7/15 with diagnoses including dementia and psychotic disorder with delusions.</p> <p>Resident #48 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 4/4/15 indicated she was moderately impaired cognitive skills for daily decision making. No behaviors nor rejection of care were noted. The resident required limited assistance for all of her Activities of Daily Living (ADLs) with the exception of requiring extensive assistance for dressing and toileting; and supervision only for locomotion on the unit. She utilized a walker as a mobility device. Resident #48 was assessed as occasionally incontinent of bladder and bowel.</p>	Room	Degrees F	#101	110	#103	110	#109	111	#201	111	F 323		
Room	Degrees F													
#101	110													
#103	110													
#109	111													
#201	111													

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F 323	<p>Continued From page 43</p> <p>The MDS fall history revealed the resident had 2 or more falls without injury since her last assessment. A Fall Risk Assessment dated 4/4/15 indicated Resident #48 was categorized as being at a " High Risk for Falling " based on an assessment score of 65 (high risk determined by a score of greater than 45).</p> <p>A review of the resident's Care Area Assessment (CAA) dated 7/1/14 revealed Resident #48 was determined to be at risk for falls due to extreme weakness at that time. The CAA Summary dated 7/1/14 indicated a decision was made to address a problem related to falls in her care plan.</p> <p>Resident #48 ' s current care plan was initiated on 10/8/14 and reviewed by facility staff on 2/25/15. The current care plan did not include a focus area for falls or accident prevention through the date of review (5/21/15).</p> <p>Resident #48 ' s medical record and incident reports from the past 6 months were reviewed. The records revealed Resident #48 had sustained 8 falls between 12/18/14 and the date of the review (5/21/15).</p> <p>Fall #1-- An Incident Report dated 12/18/14 reported the resident had an unwitnessed fall without injury. The resident was found on the floor between the bed and bathroom; the resident stated that she was hurrying from the bathroom and slipped. She had indicated that the socks she was wearing had caused the fall. The resident was assisted from the floor to her wheelchair, non-skid stockings were applied, and the resident was encouraged to call for assistance. On 12/18/14, A Director of Nursing (DON) Review of</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>this incident indicated it was not necessary to revise Resident #48 ' s Care Plan.</p> <p>Fall #2- A review of Resident #48 ' s medical record indicated the resident ' s physician was notified by fax on 1/9/15 at 4:00 PM related to a fall without injury. No Fall Incident Report was available for review in regards to the fall occurring on 1/9/15. The medical record did not include a Nursing Incident Note dated 1/9/15.</p> <p>Fall #3 - An Incident Report dated 2/1/15 reported the resident had an unwitnessed fall without injury. The resident was found on the floor in her room with her back against a chair at the bedside. Upon questioning by the nurse, the resident revealed she was trying to move a basin of bath water when she fell. She was wearing regular socks at the time of the fall. The resident was instructed to use her call bell for assistance, non-skid socks were provided, and the resident was encouraged to wear them. A Fall Scene Investigation Report dated 2/1/15 identified the root cause of this fall as footwear (socks). The initial interventions put into place to prevent future falls included providing nonskid footwear and encouraging the resident to use the call bell if she needed assistance. On 2/5/15, a DON Review of this incident indicated it was not necessary to revise Resident #48 ' s Care Plan.</p> <p>Fall #4 - An Incident Report dated 2/15/15 reported the resident had a witnessed fall without injury. The resident was reported as coming out of the bathroom with her walker. She stated her legs gave out and her roommate ' s visitor lowered her</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>to the floor. Immediate action taken was noted as, " Monitor. " A Fall Scene Investigation Report dated 2/15/15 identified the root cause of the fall as, " Amount of assistance in effect. " The written response noted for initial interventions to prevent future falls read, " Resident may need alarm. " On 2/23/15, a DON Review of this incident indicated the need for revision of the Resident #48 ' s care plan was " N/A (not applicable). "</p> <p>Fall #5 - An Incident Report dated 2/16/15 reported the resident had a witnessed fall without injury. A staff member reported that the resident ' s left leg became weak and she was lowered to the floor. Immediate action taken included submitting a request for a therapy screen on 2/23/15 due to the resident ' s weakness and recent falls. A Fall Scene Investigation Report (not dated) identified the root cause of the fall as weakness. On 2/26/15, a DON Review of this incident indicated it was not necessary to revise Resident #48 ' s Care Plan.</p> <p>A review of the resident ' s medical record included a Therapy Follow-Up/Referral S/P (status post) Fall form dated 2/23/15. A Therapy Department progress note dated 2/25/15 indicated the resident had a recent illness and was not an appropriate candidate for skilled Physical Therapy (PT) at that time.</p> <p>Fall #6 - An Incident Report dated 4/7/15 reported the resident had an unwitnessed fall without injury. The resident was found on the floor with her wheelchair turned to the side. Upon questioning, the resident reported, " I was going to the closet</p>	F 323			

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F 323	<p>Continued From page 46 and hit the wheelchair, knocking it on its side. " Immediate action taken included reminding the resident to call for assistance and recommending increased monitoring by staff.</p> <p>Fall #7 - An Incident Report dated 4/30/15 reported the resident had an unwitnessed fall. The resident was found lying on the floor on her left side with her head on a pillow. Upon questioning, the resident reported she was trying to get in the bed. Immediate action taken was reported as reinforcing with the resident to call for assistance when transferring and ambulating in room. A Fall Scene Investigation Report (FSI) dated 4/30/15 identified the root cause of the fall as weakness and poor safety awareness. The FSI report indicated the resident was wearing shoes at the time of the fall. Footwear and medical status/physical condition/diagnoses were identified as contributing factors to the fall. The FSI noted an alarm was not being used at the time of the fall.</p> <p>Fall #8 - An Incident Report dated 5/10/15 reported the resident had an unwitnessed fall. The resident was found lying on the floor in her room. Upon questioning, the resident reported " I was tired and sat down. " Immediate action taken was reported as reinforcing with the resident to call for assistance when transferring and ambulating in room. An X-ray of the resident ' s left hip and sacrum was taken on 5/10/15 with the results reported to be within normal limits. A Fall Scene Investigation Report dated 5/10/15 noted an alarm was not being used at the time of the fall. Hand-written supplementary notes on the DON Review form dated 5/10/15 read, in part: " Alarm had been removed by resident or there is</p>	F 323			

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F 323	<p>Continued From page 47 not one. Checked-could not find. "</p> <p>On 5/19/15 at 9:15 AM, an observation was made of the Resident #48 sitting in a reclined geri-chair next to her bed. The resident's bedside tray table was not within her reach. A call light was lying on the bed and within reach of the resident. Upon inquiry, the resident indicated she was not sure what the call light button was or what it was supposed to be used for.</p> <p>An interview was conducted on 5/20/15 at 1:49 PM with Nurse #7. Nurse #7 assumed responsibility for completing the facility ' s MDS assessments. During the interview, the nurse discussed the process implemented by the facility in response to a resident experiencing a fall. Nurse #7 indicated that when a resident had a fall, that resident and the circumstances of the fall would be discussed at the next weekday morning clinical meeting. During the meeting, potential fall prevention interventions would be discussed and decisions made as to which interventions could be implemented to reduce the risk for further falls/injuries. After this clinical meeting, Nurse #7 indicated she was responsible for updating the resident ' s care plan with any changes made in the interventions implemented after a fall.</p> <p>An interview was conducted on 5/20/15 at 2:26 PM with the facility ' s Interim Director of Nursing (DON). During the interview, the DON reviewed the facility ' s usual procedures for investigating a fall incident and implementing fall prevention interventions for a resident. The DON reported a screening referral was made to the Therapy Department after any fall was sustained by a resident. The DON indicated that every time a resident sustained a fall, she would expect the</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>facility to do an investigation, assess and evaluate potential fall prevention interventions to be put into place for him/her, and revise the resident ' s care plan as needed to reflect the interventions implemented.</p> <p>An interview was conducted on 5/20/15 at 3:12 PM with Nursing Assistant (NA) #2. NA #2 was assigned to care for Resident #48. During the interview, the NA discussed fall interventions put into place for the resident. NA #2 reported the resident needed to be toileted every 2 hours; had a personal body alarm in place; and required personal items to be kept within her reach.</p> <p>An interview was conducted with the facility ' s Rehabilitation (Rehab) Manager on 5/20/15 at 4:10 PM. The Rehab Manager discussed his department ' s role in screening and evaluating residents who experienced a fall. He reported after each fall, nursing would generate a request to have Therapy screen the resident. Based on findings from the post-fall screen, it would be determined whether or not a resident may benefit from therapy services. All screenings, evaluations, and therapy notes were filed in the resident ' s paper medical record. A review of Resident #48 ' s paper medical record was completed with the Rehab Manager. The review revealed one Therapy post-fall screen dated 2/25/15 was completed for Resident #48. During a follow-up interview conducted on 5/20/15 at 4:57 PM, the Rehab Manager reported no additional Therapy screens had been completed for Resident #48 during the past 6 months. He indicated during that time period, Therapy post-fall screen referrals had not been routinely generated in accordance with facility ' s established procedures.</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>An observation of Resident #48 was made on 5/21/15 at 8:00 AM. The resident was observed to be sleeping in bed with one-half side rails raised on both sides of the bed with the bed placed in a low position. The resident ' s tray table was placed approximately four feet away from the bed and out of reach of the resident. A bed alarm was noted to be in place.</p> <p>An interview was conducted on 5/21/15 at 5:13 PM with NA #5. NA #5 was the 2nd shift NA assigned to care for Resident #48. Upon inquiry, the NA discussed the fall prevention interventions put into place for this resident due to her history of falls. NA #5 noted the resident ' s bed was kept in the low position and she used either non-skid socks or shoes to help prevent slipping. The NA also reported that she checked on the resident every 15 minutes during her shift, offered frequent toileting, monitored a body alarm for the resident, and kept her room free of clutter. Given the observation made at 8:00 AM that morning when the tray table was positioned several feet away from her bed while the resident was lying down, the NA responded, " No ...that needs to be within reach for her. " Upon inquiry as to how she would know what fall prevention interventions needed to be implemented for an individual resident, the NA reported that if she had not worked on a particular hall for a while, she would need to seek out that information from multiple sources, including reviewing the 24-hour report and asking the hall nurse about any changes made for a resident.</p> <p>An observation of Resident #48 was made on 5/22/15 at 8:10 AM sitting in a wheelchair in her room. She was observed to be wearing regular</p>	F 323			

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F 323	<p>Continued From page 50</p> <p>cotton socks. The resident was alone in her room.</p> <p>An interview was conducted on 5/22/15 at 8:15 AM with NA #2. NA #2 was the first shift nursing assistant assigned to care for Resident #48. Upon inquiry, the NA reported the resident was supposed to wear nonskid socks versus the regular cotton socks on her feet at that time. NA #2 stated she would need to put nonskid socks on her. When asked how the NA would know what kind of socks the resident needed to wear, NA #2 stated, "Because she's my resident and she's on fall precautions." Upon inquiry, the NA indicated there was not a specific communication piece which would provide information on the fall prevention interventions needing to be implemented for a particular resident.</p> <p>An interview was conducted with the Interim DON on 5/22/15 at 12:15 PM in regards to how fall safety interventions for Resident #48 were communicated to staff, monitored for implementation, and updated to ensure the appropriateness/effectiveness of them. The DON reported some of Resident #48 's interventions were listed in the resident 's electronic Point of Care system, including a toileting program (every 2-3 hours) and a body alarm check (every shift). The DON reported the facility 's standard practice was to put non-skid socks on any resident not wearing regular shoes. She indicated the remaining interventions would be put on as a " task " in the electronic system. The DON stated her expectation was for fall prevention interventions in place to be care-planned for a resident, all staff made aware of these interventions via the electronic Point of Care system, and checks completed by the hall</p>	F 323			

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F 323	Continued From page 51 nurse to be sure the fall prevention interventions were implemented as planned.	F 323			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of kitchen checklist and procedures, the facility failed to maintain sanitary conditions in the kitchen by ensuring 1.) the steam table serving pans were air dried properly, 2.) Muffin pans were clean and air dried, 3.) the meal carts were clean and free from dried food and liquid debris, 4.) the dry products storage containers were clean and free of dried food/liquid debris, 5.) the plate warmer box was clean and free of dried food debris, 6.) the outside of ice machine was clean and free of dried foods and liquids 7) remove the dried foods from 5 crates of bowls and cups and air dry properly, and 8) remove dried foods from 3 large clear storage containers. The findings included: 1. During a kitchen tour on 5/18/15 at 11:50AM, there were 7 long silver serving pans, 3 short	F 371	1) The steam table serving pans cleaned and properly air dried daily by assigned dietary staff. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QA/QI Committee. Monitoring will continue for a minimum of 12 months. 2) The muffin pans are clean and properly air dried daily by assigned dietary staff. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their	6/18/15	

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F 371	<p>Continued From page 52</p> <p>silver pans, 2 medium pans and 3 medium size pans and 2 steam table lids were stacked wet. The 2 steam table lids had dried food debris stored on the inside and they were stored on the dry storage rack.</p> <p>During an interview on 5/18/15 at 12:00PM, the registered dietician (RD) and food service director (FSD) indicated it was the dishwasher ' s responsibility to ensure there was no food debris left in the pans and they should not be stacked on top of one another. The kitchen equipment and dishes should be air dried.</p> <p>During an interview on 5/18/15 at 12:05PM, the dishwasher staff indicated that he was responsible for ensuring that dishes/pans were not stacked wet, they should be staggered. He also indicated that kitchen equipment should be wiped down daily. Staff confirmed the pans were stacked wet and the meal carts needed to be cleaned.</p> <p>(2). During a kitchen tour on 5/18/15 at 11:50AM, there was 2 muffin pans were located on the dry storage rack stacked wet and food debris was found on the inside of the muffin cups.</p> <p>During an interview on 5/18/15 at 12:00PM, the RD and FSD indicated it was the dishwasher ' s responsibility to ensure there was no food debris left in the pans and they should not be stacked on top of one another. The kitchen equipment and dishes should be air dried.</p> <p>During an interview on 5/18/15 at 12:05PM, the dishwasher staff indicated that he was responsible for ensuring that dishes/pans were not stacked wet, they should be staggered. He</p>	F 371	<p>designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>3)All patient food carts are checked for cleanliness prior to loading any food on carts daily by assigned dietary staff. If carts are not cleaned, catering associate will return carts to dish room to be cleaned. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>4)The dry products storage containers are cleaned daily to ensure free of dried food and liquid debris. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>5)The plate warmer box are cleaned daily to ensure the plate warmer box is free of dried foods and liquids. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to</p>		

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F 371	<p>Continued From page 53</p> <p>also indicated that kitchen equipment should be wiped down daily. Staff confirmed the pans were stacked wet and the meal carts needed to be cleaned.</p> <p>(3). During a kitchen tour on 5/18/15 at 11:50AM, there was 2 meal carts that were dirty on the inside that with dried foods/liquids. The carts were being used and prepared for the lunch meal.</p> <p>During an interview on 5/18/15 at 12:00PM, the RD and FSD, indicated the equipment should be cleaned daily after each usage.</p> <p>(4). During a kitchen tour on 5/8/15 at 11:50AM, the dry products containers 2 flour and 1 sugar was dirty with dried/liquids food on surfaces on the inside and outside where the dry products were stored.</p> <p>During an interview on 5/18/15 at 12:00PM, the RD and FSD indicated the containers should be wiped down daily and after each usage.</p> <p>(5) During a kitchen observation n 5/18/15 at 11:50AM, the hot plate warmer had large volumes of dried food and liquid build up on the inside and outside, where the clean plates were being used. Several of the plates had dried food cooked on the outside surfaces.</p> <p>During an interview on 5/18/15 at 12:00PM, the RD and FSD indicated the kitchen equipment should be cleaned daily and the head cook was responsible for monitoring and ensuring things were cleaned and orderly per the kitchen checklist.</p> <p>(6). During a kitchen observation on 5/18/15 at</p>	F 371	<p>leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>6)The outside of the ice machine cleaned daily to ensure the ice machine is free of dried foods and liquids. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Registered Dietitian or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>7)Removal of dried foods from crates of bowls and cups performed daily and bowls and cups are air dried properly daily by assigned dietary staff. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>8)Removal of dried food from 3 large clear storage containers performed daily by assigned dietary staff. Monitoring will be done by the Food Services Director, Executive Chef, or their designee. Dietary</p>		

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F 371	<p>Continued From page 54</p> <p>11:50AM, the ice machine was dirty with heavy build-up of dried foods/liquids on outside.</p> <p>During an interview on 5/18/15 at 12:00PM, the RD and FSD indicated the ice machine should be wiped down daily after each shift.</p> <p>(7). During a follow-up kitchen observation on 5/21/15 at 11:45AM, there were 5 crates of bowls/cup that had food debris on the inside/outside and they were also stacked on top of wet, clear storage food containers were stored under preparation table with dried food debris.</p> <p>During an interview on 5/21/15 at 11:45AM, the FSD also indicated that the RD and lead cook was responsible for ensuring the kitchen equipment/dishes were cleaned, dried and storage properly. The cups/bowls should be aired dried and stacked on top one another. The cook should follow the daily Clean As you Go checklist to ensure the staff are completing the cleaning task.</p> <p>During an interview on 5/21/15 at 12:00PM, lead cook, confirmed that he was responsible for ensuring that the kitchen staff were cleaning the kitchen equipment and dishes properly and not storing kitchen equipment dirty. He added the daily Clean As you Go checklist should be followed. The cook confirmed the carts should be clean daily after each shift, dishes/equipment should be cleaned and air dried.</p> <p>During a follow-up interview on 5/21/15 at 2:04PM, RD indicated that lead cook was responsible for doing the monitoring/checking to ensuring the kitchen was clean orderly and run properly.</p>	F 371	<p>staff will be checked off daily prior to leaving their shift by the Food Service Director, Executive Chef or their designee. A copy of the weekly cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>The Executive Chef or designee will in service all production staff on how to read and understand their role and responsibilities of the Main Kitchen Cleaning Schedule.</p> <p>Registered Dietitian or designee to in service all Brantwood staff on how to read and understand their role and responsibilities of the Brantwood Kitchen Cleaning Schedule.</p> <p>The Supervisor is to monitor the Main Kitchen Cleaning Schedule daily to ensure all staff have completed and signed off on their daily cleaning task. Daily monitoring to be done by dietary management. A copy of the cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p> <p>Registered Dietitian or supervisor is to monitor daily the Brantwood Kitchen Cleaning Schedule to ensure all staff have completed and signed off on their daily cleaning task. A copy of the cleaning schedule is provided to the QAQI Committee. Monitoring will continue for a minimum of 12 months.</p>		

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F 371	Continued From page 55	F 371			
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>	F 431	<p>Granville Health System's Infection Control Nurse will inspect the main kitchen at the hospital and the kitchen at Brantwood monthly. The inspection to include sanitation/cleanliness of both kitchens. This report will be sent to the Administrator and Food Services Director each month. The report will be submitted to the QA/QI Committee monthly for a minimum of 12 months. Any non-compliance will have an action plan.</p>	6/23/15	

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F 431	<p>Continued From page 56</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard expired medications as specified by the manufacturer and/or auxiliary labeling provided by the pharmacy in 1 of 2 medication rooms (Back Hall Medication Room) and in 2 of 4 medication carts (300 Hall Medication Cart and 200 Hall Medication Cart).</p> <p>The findings included:</p> <p>1a) An observation made of the contents of the Back Hall Medication Room on 5/22/15 at 2:20 PM revealed an opened vial of Lantus insulin stored in the refrigerator was expired. The Lantus insulin was labeled for use by Resident #18. A handwritten note on the insulin vial itself indicated the insulin was opened on 4/14/15; a handwritten note on the outside container storing the vial indicated the insulin was opened on 4/13/15. Pharmacy labeling on the outside container storing the insulin vial included a statement which read, "Discard 28 days after opening."</p> <p>The manufacturer ' s product information</p>	F 431	<p>For residents #18, #64, #33, and #40, expired medications were discarded on 5/22/15. Expired medications found in the Back Hall Medication Room , 200 Hall Medication Cart and 300 Hall Medication Cart were discarded on 5/22/2015.</p> <p>All medication carts and medication storage rooms were inspected to ensure compliance on 5/22/15.</p> <p>To ensure the deficient practice does not reoccur for residents #18, #64,#33, and #40 or occur for other residents, for medications which expire within a specific time period from date opened, hall nurses will label medications with the date opened and the date on which the medication will expire. Third shift Hall nurses will monitor medications on the medication carts and medication storage rooms daily and discard any expired medications. The Clinical Nurse Manager or designee will monitor, for compliance, medication carts and medication storage rooms weekly for expired medications.</p>		

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F 431	<p>Continued From page 57 indicated once punctured (in use), Lantus insulin vials may be stored under refrigeration or at room temperature for up to 28 days.</p> <p>A review of Resident #18 ' s May 2015 Physician Orders revealed there was a current order for Lantus insulin to be given twice daily. Information provided by Resident #18 ' s May 2015 Medication Administration Record (MAR) indicated the resident received a dose of Lantus insulin 19 times after the insulin ' s calculated expiration date of 5/12/15.</p> <p>An interview was conducted with the 200 Hall Nurse (Nurse #4) on 5/22/15 at 2:25 PM. During the interview, Nurse #4 stated Lantus insulin should be discarded within 28 days after opening. The nurse indicated she recently looked at the expiration dates of all medications stored in the medication room refrigerator, but must have missed this expired vial of Lantus insulin.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM. During the interview, the DON stated her expectation was for the Clinical Manager to check for expired medications every week; and, for the nursing staff to check the expiration date of all medications to be sure they were not expired. The DON indicated expired medications needed to be discarded.</p> <p>1b) An observation made of the contents of the Back Hall Medication Room on 5/22/15 at 2:20 PM revealed an opened vial of Lantus insulin stored in the refrigerator was expired. The Lantus insulin was labeled for use by Resident #64. A handwritten note on both the outside container storing the vial and on the vial itself</p>	F 431	Monitoring to continue for 3 months. Any non-compliance will be reported to the QA/QI Committee for follow-up action as needed.		

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F 431	<p>Continued From page 58 indicated the insulin was opened on 4/18/15. Pharmacy labeling on the outside container storing the insulin vial included a statement which read, "Discard 28 days after opening."</p> <p>The manufacturer ' s product information indicated once punctured (in use), Lantus insulin vials may be stored under refrigeration or at room temperature for up to 28 days.</p> <p>A review of Resident #64 ' s May 2015 Physician Orders revealed there was a current order for Lantus insulin to be given once daily. Information provided by Resident #64 ' s May 2015 Medication Administration Record (MAR) indicated the resident received a dose of Lantus insulin 5 times after the insulin ' s calculated expiration date of 5/16/15.</p> <p>An interview was conducted with the 200 Hall Nurse (Nurse #4) on 5/22/15 at 2:25 PM. During the interview, Nurse #4 stated Lantus insulin should be discarded within 28 days after opening. The nurse indicated she recently looked at the expiration dates of all medications stored in the medication room refrigerator, but must have missed this expired vial of Lantus insulin.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM. During the interview, the DON stated her expectation was for the Clinical Manager to check for expired medications every week; and, she expected nursing staff to check the expiration date of all medications to be sure they were not expired. The DON indicated expired medications needed to be discarded.</p> <p>1c) An observation made of the contents of the</p>	F 431			

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F 431	<p>Continued From page 59</p> <p>Back Hall Medication Room on 5/22/15 at 2:20 PM revealed an opened vial of Tuberculin Purified Protein Derivative (PPD) injectable medication (an injectable medication used as a screening test for tuberculosis) stored in the refrigerator was expired. A handwritten note on the Tuberculin PPD medication indicated the vial was opened on 4/11/15. Manufacturer ' s labeling on the box containing the opened vial of the injectable medication read in part, "Discard opened product after 30 days. "</p> <p>During an interview with Nurse #4 on 5/22/15 at 1:25 PM, the nurse stated a vial of Tuberculin PPD injectable medication should be discarded after being open for 30 days. She indicated this vial of Tuberculin PPD was expired and should be discarded.</p> <p>During an interview with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM, the DON addressed the normal procedure for storing opened injectable medications such as Tuberculin PPD. The DON indicated that a vial of Tuberculin PPD injectable medication should have been discarded within 30 days after opening in accordance with the manufacturer ' s recommendation.</p> <p>2a) An observation made of the 300 Hall Medication Cart on 5/22/15 at 2:55 PM revealed an opened vial of Humulin 70/30 insulin stored on the cart was expired. The Humulin 70/30 insulin was labeled for use by Resident #33. A handwritten note on the insulin vial itself indicated the insulin was opened on 4/14/15. An auxiliary sticker placed on the insulin vial read, " Roll in hand-Expires 28 days after opened. " Pharmacy labeling on the outside container</p>	F 431			

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F 431	<p>Continued From page 60</p> <p>storing the insulin vial included a statement which read, "Discard 28 days after opening."</p> <p>The manufacturer ' s product information indicated once punctured (in use), Humulin 70/30 insulin vials may be stored under refrigeration or at room temperature for up to 31 days.</p> <p>A review of Resident #33 ' s May 2015 Physician Orders revealed there was a current order for Humulin 70/30 insulin to be given twice daily. Information provided by Resident #33 ' s May 2015 Medication Administration Record (MAR) indicated the resident received a dose of Humulin 70/30 insulin 13 times after the insulin ' s calculated expiration date of 5/15/15.</p> <p>An interview was conducted with the 300 Hall nurse (Nurse #8) on 5/22/15 at 3:10 PM. During the interview, Nurse #8 stated insulin expired 28 days after opening. Upon inquiry, the nurse indicated all hall nurses using a medication cart shared the responsibility to check expiration dates of medications and insulin stored on the cart.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM. During the interview, the DON stated her expectation was for the Clinical Manager to check for expired medications every week; and, for the nursing staff to check the expiration date of all medications to be sure they were not expired. The DON indicated expired medications needed to be discarded.</p> <p>2b) An observation made of the 300 Hall Medication Cart on 5/22/15 at 2:55 PM revealed an opened vial of Lantus insulin stored on the cart</p>	F 431			

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F 431	<p>Continued From page 61</p> <p>was expired. The Lantus insulin was labeled for use by Resident #33. A handwritten note on the insulin vial itself indicated the insulin was opened on 4/21/15. An auxiliary sticker placed on the insulin vial read, " Roll in hand-Expires 28 days after opened. " Pharmacy labeling on the outside container storing the insulin vial included a statement which read, "Discard 28 days after opening."</p> <p>The manufacturer ' s product information indicated once punctured (in use), Lantus insulin vials may be stored under refrigeration or at room temperature for up to 28 days.</p> <p>A review of Resident #33 ' s May 2015 Physician Orders revealed there was a current order for Lantus insulin to be given once daily. Information provided by Resident #33 ' s May 2015 Medication Administration Record (MAR) indicated the resident received a dose of Lantus insulin 2 times after the insulin ' s calculated expiration date of 5/19/15.</p> <p>An interview was conducted with the 300 Hall nurse (Nurse #8) on 5/22/15 at 3:10 PM. During the interview, Nurse #8 stated insulin expired 28 days after opening. Upon inquiry, the nurse indicated all hall nurses using the medication cart shared the responsibility to check expiration dates of medications and insulin stored on the cart.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM. During the interview, the DON stated her expectation was for the Clinical Manager to check for expired medications every week; and, for the nursing staff to check the expiration date of all</p>	F 431			

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F 431	<p>Continued From page 62</p> <p>medications to be sure they were not expired. The DON indicated expired medications needed to be discarded.</p> <p>3) An observation made on 5/22/15 at 2:15 PM revealed a box of levalbuterol 1.25 milligrams (mg) / 3 milliliters (ml) solution for oral inhalation labeled for Resident #40 was stored on the 200 Hall medication cart. The box contained 12 vials of medication in one sealed, protective foil pouch; and one opened foil pouch with 4 vials of medication remaining in that pouch. A hand-written note on the opened foil pouch indicated the pouch was " opened 4/3/15. "</p> <p>Manufacturer labeling on the front of the levalbuterol box read, in part, " Unit-dose vials should remain stored in the protective foil pouch at all times. Once the foil pouch is opened, the vials should be used within two weeks. " The pharmacy label attached to the levalbuterol box included the following notation, " Discard 2 weeks in pouch after foil is opened or 1 week out of pouch. "</p> <p>A review of Resident #40 ' s May 2015 Physician ' s Orders revealed there was a current medication order for levalbuterol 1.25 mg / 3 ml solution to be used as one vial via nebulizer every four hours as needed. The order included a notation, " Discard 2 weeks in pouch after foil is opened or 1 week out of pouch. "</p> <p>A review of the April 2015 and May 2015 Medication Administration Record (MAR) for Resident #40 revealed the levalbuterol nebulizer solution had not been used after the medication ' s calculated expiration date of 4/17/15.</p>	F 431			

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F 431	<p>Continued From page 63</p> <p>An interview was conducted with Nurse #4 on 5/22/15 at 2:19 PM. Nurse #4 was assigned to the 200 Hall medication cart. After reviewing the medication labeling, the nurse stated levalbuterol vials needed to be used within two weeks once the foil pouch was opened. Nurse #4 then indicated the 4 vials of levalbuterol remaining in the opened pouch were expired and needed to be discarded.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 5/22/15 at 4:30 PM. Upon inquiry, the DON indicated the manufacturer ' s recommendations needed to be utilized to determine the medication ' s expiration date. Any remaining levalbuterol vials should have been discarded two weeks after the protective foil pouch was opened.</p>	F 431			