STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 03/04/2016

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SENTARA NURSING CENTER	3907 CARATOKE HIGHWAY BARCO, NC 27917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 205 SS=B	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and family and staff interviews, the facility failed to provide the written bed hold policy within 24 hours of resident's discharge to the hospital, for 1 of 1 residents (resident #56) reviewed for transfers. The findings included: Resident #56 was admitted to the facility on 12/31/2015, with diagnoses to include dementia and fractured right ankle. On 1/5/2016 the resident was transferred to the hospital after a fall, and re-admitted to the facility on 1/13/2016. A review of the facility's " Life Care - Bed-hold Policy " revised on 11/10/2015, included the bulletin point; " All Residents or their Responsible	F 205	**Preparation and or execution of This Plan of Correction does not constitute admission by the Provider of the truth of the Facts alleged or conclusion set Forth in the Statement of Deficiencies. The Plan of Correction is prepared solely because it is required by law. This Plan of Correction is Submitted as our Allegation of Compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3.18.16

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 205	Continued From page 1 Party will be provided a ' Notice of Bed Hold Policy ' letter at time of transfer; if not immediately possible, notification will be at the first available opportunity. (Notification should not exceed 24 hours after time of transfer.) " An interview was conducted with the resident's responsible party (RP) on 3/3/2016 at 2:00 PM. The RP stated he did not receive information about a bed hold policy when the resident was admitted, or when she was transferred to the hospital on 1/5/2016. He indicated he did not receive a phone call about the bed hold policy after she was admitted to the hospital. An interview was conducted with the Social Worker (SW) on 3/3/2016 at 3:01 PM. The SW stated the bed hold policy was the 1st policy reviewed in the orientation handbook for residents. The SW indicated she did not have a signature on file that the resident or RP received the handbook on admission. The SW stated she did not call the resident or the RP after the transfer to the hospital, and she had no documentation that the RP was called. On 3/4/2016 at 11:27 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was the responsibility of the SW to notify the family of the bed hold policy. On 3/4/2016 at 12:09 PM, an interview was conducted with the Administrator, who stated the RP had not been given a copy of the bed hold policy on admission.	F 205	F – 205 Bed Hold 1. Resident #76 has not had any subsequent Leaves and continues to receive care. A photo copy of the original agreement has been provided for additional resource. 2. Residents that have emergent & therapeutic leaves had the potential of being affected and are in receipt of bed hold agreement. 3. Licensed staff and Social Services educated to the Bed hold policy and times of notification requirement. 4. Random audits to be completed weekly on LOAs and emergent transfers for compliance of bed hold notification x one month by the ADMIN and or designee. Results of audits to be reported to QAPI for review and recommendations 5. Date of Compliance April 9, 2016	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		

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F 278	Continued From page 2 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to correctly code the Minimum Data Set (MDS) for 4 of 6 residents (Residents #76, 70, 33 and 75) with a Level II Pre-Admission Screening and Resident Review (PASRR) and failed to complete the cognitive assessment accurately for 1 of 16 residents (resident #56) whose MDS was reviewed. Findings included: 1. Resident # 76 was admitted to the facility on	F 278	F-tag – 278 Accuracy of Assessment 1. Resident's #76, #33, #75 & #56 MDS Modifications were completed prior to exit on 3-4-16. 2. All residents requiring PASSAR level II & BIMS have the potential to be affected. 3. Audits of PASSARs & BIMS Coding to be completed to determine the accuracy of PASSAR levels & BIMS is reflected in the MDS correctly. The Admissions Personnel to be educated on the state specifics on PASSAR Levels of Care. Admissions, SSD & MDSC are to communicate all admission PASSAR Levels upon admission w/verification in EMR. MDSC educated on PASSAR locations in EMR to complete section A of MDS and review of Section B & C for BIMS.	

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F 278	Continued From page 3 2/11/16. She was identified with a Level II PASRR in her admission records. Review of her 2/18/16 Admission MDS, failed to code the resident as having a Level II PASRR. The MDS nurse was interviewed on 3/3/16 at 4:12 PM. She stated she was responsible for coding Section A of the MDS. The MDS nurse added the Social Worker (SW) was responsible for notifying her if any resident had been identified as a Level II PASRR. The information was emailed to her or communicated face to face during morning meetings. The MDS nurse reviewed the Admission MDS for Resident #76, acknowledged the MDS had not been coded to reflect the Level II PASRR and added she was unaware of the resident's PASRR level. On 3/3/16 at 4:37 PM, the SW was interviewed. She acknowledged she received information about which residents were a Level II PASRR from the state agency. She stated while she did not verbally share this information, it was available in the facility's computer system. The SW stated she was unaware the MDS nurse would need this information in order to code the MDS. She stated no one had instructed her to share the information with the MDS nurse. 2. Resident #70 was admitted on 12/10/15 with a Level II PASRR. On review of his 12/17/15 Admission MDS, the section to note a Level II PASRR had been coded to reflect he did not have a Level II PASRR. The MDS nurse was interviewed on 3/3/16 at 4:12 PM. She stated she was responsible for coding Section A of the MDS. The MDS nurse	F 278	4. Admin and or designee to review new admit documentation for Section A along with section C weekly for four weeks and monthly thereafter for one quarter for accuracy and completion. The results of audits will be submitted for review and or recommendation to the QAPI Committee. 5. Date of Compliance April 9, 2016.	

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F 278	Continued From page 4 added the Social Worker (SW) was responsible for notifying her if any resident had been identified as a Level II PASRR. The information was emailed to her or communicated face to face during morning meetings. The MDS nurse reviewed the Admission MDS for Resident #70, acknowledged the MDS had not been coded to reflect the Level II PASRR and added she was unaware of the resident's PASRR level. On 3/3/16 at 4:37 PM, the SW was interviewed. She acknowledged she received information about which residents were a Level II PASRR from the state agency. She stated while she did not verbally share this information, it was available in the facility's computer system. The SW stated she was unaware the MDS nurse would need this information in order to code the MDS. She stated no one had instructed her to share the information with the MDS nurse. 3. Resident #33 was readmitted on 2/23/15 with a Level II PASRR. Review of his 4/3/15 Annual Assessment failed to identify the resident as having a Level II PASRR. The MDS nurse was interviewed on 3/3/16 at 4:12 PM. She stated she was responsible for coding Section A of the MDS. The MDS nurse added the Social Worker (SW) was responsible for notifying her if any resident had been identified as a Level II PASRR. The information was emailed to her or communicated face to face during morning meetings. The MDS nurse reviewed the Admission MDS for Resident #33, acknowledged the MDS had not been coded to reflect the Level II PASRR and added she was unaware of the resident's PASRR level.	F 278		

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F 278	Continued From page 5 On 3/3/16 at 4:37 PM, the SW was interviewed. She acknowledged she received information about which residents were a Level II PASRR from the state agency. She stated while she did not verbally share this information, it was available in the facility's computer system. The SW stated she was unaware the MDS nurse would need this information in order to code the MDS. She stated no one had instructed her to share the information with the MDS nurse. 4. Resident #75 was admitted on 12/12/13 with a Level II PASRR. The most current comprehensive assessment, an annual dated 10/5/16, did not identify the resident with a Level II PASRR. The MDS nurse was interviewed on 3/3/16 at 4:12 PM. She stated she was responsible for coding Section A of the MDS. The MDS nurse added the Social Worker (SW) was responsible for notifying her if any resident had been identified as a Level II PASRR. The information was emailed to her or communicated face to face during morning meetings. The MDS nurse reviewed the Admission MDS for Resident #75, acknowledged the MDS had not been coded to reflect the Level II PASRR and added she was unaware of the resident's PASRR level. On 3/3/16 at 4:37 PM, the SW was interviewed. She acknowledged she received information about which residents were a Level II PASRR from the state agency. She stated while she did not verbally share this information, it was available in the facility's computer system. The SW stated she was unaware the MDS nurse would need this information in order to code the MDS. She stated no one had instructed her to	F 278		

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F 278	Continued From page 6 share the information with the MDS nurse. 5. Resident #56 was admitted on 12/31/15 with diagnoses that included dementia. Review of the 1/5/16 Admission MDS indicated the resident was usually understood and usually able to understand. The BIMS was not attempted and Resident #56 was assessed as having short and long term memory impairment with moderately impaired cognitive skills for daily decision making The MDS nurse, was interviewed on 3/3/16 at 4:12 PM. She stated she was responsible for completing the cognitive assessments on residents. On review of Resident #56's MDS, the MDS nurse stated she should have attempted the BIMS for Resident #56 and the results on the MDS were inaccurate and she would need to submit a corrected MDS.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, Responsible Party (RP) and staff interviews and interviews with the surgeon's nurse and record review, the facility	F 309	F tag – 309 Provide Care/Services for highest well being 1. Resident #56 has subsequently returned to facility and continues to receive care. The Staff involved have had further education on changes in condition along with timely notification. 2. Any residents with a change in condition have the potential to be affected. The Clinical Managers to Audit for appropriate follow up & timely response on change in conditions. 3. All licensed staff has been educated on the use of SBAR with a change in condition, along with the C.N.A's being educated on the use of "stop and watch". Timely notification and follow up with MD. 4. DON or designee will review all SBAR/change in condition for timely notification and intervention. DON will report findings to the QAPI meeting for the next 2 quarters for review and any recommendations. 5. Date of Compliance April 9, 2016	

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F 309	Continued From page 7 failed to transfer a resident that had a significant change in condition and was receiving anticoagulants and had actual bleeding for 1 of 1 resident (Resident #56) reviewed for a change in condition. Findings included: Resident #56 was admitted on 12/31/15 with a stroke and right lower extremity fracture with open reduction and internal fixation. Review of the hospital discharge summary, dated 12/31/15 indicated Resident #56 had sustained a fall at home resulting in the trimalleolar fracture of her right ankle status post open reduction and internal fixation. Post -surgery, the resident had experienced a stroke with right hemiparesis. Discharge medications included aspirin 81 milligrams (mgs) daily and Lovenox (a medication given to reduce the risk of blood clots by thinning the blood) 40 mg daily. The summary indicated she had been discharged to the skilled nursing facility in stable condition. An admission nurse's note, dated 12/31/15 at 10:43 AM indicated Resident #56 had been admitted for strength training and rehab related to a stroke along with right sided weakness and a broken right ankle. The nurse noted a soft cast to the resident's right ankle. The Admission Fall Risk assessment identified Resident #56 as a fall risk and indicated the fall prevention protocol would be initiated. An initial care plan, dated 12/31/15 indicated Resident #56 was at risk for falls. Interventions to prevent injuries due to falls included using alarms to monitor the attempt to rise, call light within easy reach, transfers with 2 staff for safety, fallen leaf x 30 days and fall mat at the bedside along with a low bed. The resident was also identified at risk for bleeding and/or bruising related to the use of aspirin. The Lovenox was not included.	F 309		

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Interventions to maintain stable vital signs, minimal bruising with no episodes of uncontrolled bleeding included directions that if bleeding occurred to apply direct pressure or a pressure dressing if appropriate and to report any abnormal bleeding to the health care provider.
Nurse's notes, penned by Nurse #2, on 1/4/16 at 3:10 PM revealed Resident #56 had fallen while sitting on the side of the bed. Per the nurse's documentation, Resident #56 stated she was trying to get up and fell to the floor. The resident confirmed her leg was aching. The nurse documented the resident had a soft cast in place on her right ankle and blood was visible on the cast. There was no description included that measured the amount of blood seen on the resident's soft cast. The nurse noted the physician, the RP and the surgeon were all notified; adding the surgeon was to call back related to the bleeding beneath the cast.
The 1/4/16 Fall Investigation Assessment, also written by Nurse #2 indicated the resident sustained an injury resulting from the fall; adding there was bleeding under the soft cast with the word laceration underlined. Documentation entered by Nurse #2 indicated the resident did not require evaluation by the physician, did not require an X-ray and was not admitted to the hospital.
Nurse #4 entered a nurse's note on 1/4/16 at 6:38 PM. He documented the resident was post fall and was without distress. He documented the soft cast was to the lower leg. The nurse failed to document sensation, circulation, movement, pain status or the presence of blood on the soft cast.
At 11:11 PM on 1/4/16, Nurse #5 documented in the nurse's notes that Resident #56 was resting comfortably. She documented there were no late injuries noted related to the resident's fall. The

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nurse documented the soft cast was in place to Resident #56's ankle with her toes pink and capillary refill less than 3 seconds. There was no documentation that indicated the bleeding continued or had stopped.

On 1/5/16 at 3:36 PM, Clinical Manager (CM) #1 documented the orthopedic Physician's Assistant (PA) returned the call this morning regarding the resident's fall. The CM documented a moderate amount of blood was noted on the resident ' s soft cast. The CM added she had received an order to remove the soft cast and evaluate the surgical incision with transfer to the hospital if the incision was opened. The CM documented per observation of the incision, Resident #56 was sent to the hospital. There was no description of the surgical incision and no description of the amount of blood on the soft cast.

The 1/5/16 Admission Minimum Data Set (MDS) indicated Resident #56 was assessed as having short and long term memory impairment with moderately impaired cognitive skills for daily decision making Behaviors or rejection of care were not identified. Resident #56 was coded as requiring extensive assistance for bed mobility and total assistance for transfers. The MDS coded the resident as having a fall prior to admission, fracture related to a fall prior to admission and falls since admission with a non-major injury.

A 1/5/16 assessment indicated Resident #56 had increased bleeding from her ankle after multiple falls. The assessment indicated the resident was non-ambulatory, a recent admission and confused. Under Assessment, the nurse documented the resident continued to bleed from ankle surgery and the recommendation was to transfer to the hospital. The nurse also documented she called the MD and received no

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new orders, but the RP was adamant about transferring the resident to the hospital.
Nurse's notes indicated on 1/13/16 at 10:01 PM that Resident #56 was readmitted with a right below the knee amputation of her right leg, with 35 staples intact.
The orthopedic PA note, dated 1/5/16 indicated on admission the resident was found a very large dehiscence of the wound with exposure of the hardware and the malleolus. He further documented that X-ray showed internal fixation of the bimalleolar fracture which was disrupted medially and laterally with hardware and bone exposure. On admission, there was no active bleeding.
The 1/13/16 Discharge Summary indicated after discussion with the family and resident, they elected a below the knee amputation rather than pursue multiple procedures that would carry a high risk for poor outcome.
Nurse #2 was interviewed on 3/3/16 at 9:24 AM. Nurse #2 acknowledged she was the nurse caring for Resident #56 on 1/4/16 when she fell. The nurse stated she was notified by the Nursing Assistant (NA) that Resident #56 was lying on the floor in her room. The nurse stated when she arrived in the resident's room, the resident was alert, oriented and denied hitting head. Bleeding was noted coming from the soft cast on the resident's right lower extremity. She added she had not removed the soft cast to inspect the area since there were orders for the cast not to be removed. Nurse #2 stated she reported Resident #56's fall and bleeding to Clinical Manager (CM) #1 who contacted the physician.
CM #1 was interviewed on 3/3/16 at 9:39 AM. The CM stated the nurses on the hall were typically the ones that called the physicians for any change in condition. She added the nurses

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were expected to call several times and leave a message if necessary. If the nurse had not heard back from the consultant physician within a couple of hours, it was expected the nurse would call the Medical Director. The CM stated she remembered Resident #56 ' s 1/4/16 fall. She had been notified of the fall from another staff member. The CM stated she had not been the first person to call the surgeon. The CM added Resident #56 had a soft cast on her leg with orders not to remove the cast. A call was returned the next morning (1/5/16) by the orthopedic PA to remove the cast and to send the resident to the hospital for evaluation if the surgical incision had opened. She stated she removed the soft cast and found the surgical site open at the suture line with sutures appearing to have broken. The CM described Resident #56's surgical incision as approximately 1 inch long, beefy red, but not actively bleeding at the time the soft cast was removed. She acknowledged she had not documented the appearance of the surgical incision.

At 12:04 PM on 3/3/16, CM #1 reported she had reviewed the orders for Resident #56 and found there had not been an order preventing the removal of the soft cast, adding staff previously had not typically removed splints and soft casts. The CM stated she called the orthopedic surgeon on 1/4/16, time unknown and talked to the nurse who stated the surgeon would call back. She added she left the facility on 1/4/16 at around 5:00 PM at which point she had not received any direction back from the surgeon. She added the orthopedic PA had called her number back after hours and left a message on her phone. Since she had not been in the facility to answer her phone, the message went straight to voice mail. She added she had not received the message

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until 1/5/16 at approximately 9 AM. CM #1 stated while the primary care physician (PCP) was aware of the fall, she had not called the PCP back to request the cast be removed so the incision line could be assessed. She stated that while she had not called the PCP or the surgeon back, one of the nurses should have tried the PCP or the surgeon again. The CM stated she had not tried calling back because she tried to delegate responsibility and thought the calls were being taken care of by the nurses. The CM stated she was unsure of what time the soft cast was removed, but she knew it was prior to the resident's hospital transfer that occurred between 11:00 AM and noon on 1/5/16.

The resident's RP was interviewed on 3/3/16 at 1:59 PM. The RP stated he was not at the facility at the time Resident #56 fell, but had been notified. He added the soft cast encompassed the resident's entire right foot and extended to mid-calf. Before the fall on 1/4/16, he had not noticed any drainage or bleeding on the cast. After the fall, blood was seen on the medial ankle above where the incision was located and extended about 2 inches long and approximately 1/2 inch wide. On 1/5/16, prior to hospital transfer, the blood on the soft cast had extended about twice as much. The RP stated when the resident was transferred to the hospital, he saw the incision and described the incision as completely gaped open with the bone exposed. At the time he saw the incision, there was no active bleeding.

On 3/3/16 at 2:51 PM Nurse #2 was again interviewed. She stated prior to Resident #56's 1/4/16 fall there had been no bleeding or drainage from the resident's right lower extremity soft cast. The blood on the cast was noticed during the assessment completed after the fall. She stated

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F 309	Continued From page 13 after the fall, there was bright red bleeding. The nurse stated Resident #56's soft cast extended mid-calf to the toes with her toes open. Blood was observed near the ankle area measuring approximately 1 inch by a 2 inch area. She stated while the bleeding had not reached the top of the cast and the cast was not saturated with blood, she could tell the blood was coming from the inside. The nurse stated the fall occurred between 1:00-2:30 PM and she left the facility between 3:00-3:30 PM. She stated she was unsure if the surgeon had called back because she had not followed up with the CM and the CM had not reported any information back to her. Nurse #2 stated the information about Resident #56's fall, the bleeding, and the probability of the surgeon's return call were passed to the nurse for the next shift. The nurse for the orthopedic surgeon was interviewed via phone on 3/4/16 at 8:10 AM. She acknowledged the PA and the orthopedic surgeon were out of town and not available for interview. The nurse reviewed the surgeon's records for Resident #56 and stated the office had received one call from the facility on 1/4/16 at 2:16 PM from CM #1. The nurse stated CM #1's message indicated Resident #56 had fallen on her right ankle, which recently been surgically repaired after a fracture. There was no mention of bleeding. Per the notes, the nurse stated the orthopedic PA had returned the call on 1/4/16 at 5:14 PM and left a voice message. On 1/5/16, the facility called back and told the PA the resident had bleeding. The PA instructed the facility to take the resident to the hospital. The nurse stated since the resident had recent surgery, received anticoagulants and had new onset bleeding, it would have been prudent and expected that the facility would have taken the	F 309		

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resident to the hospital for evaluation if they had been unable to get in touch with the surgeon. The nurse stated per the surgeon's notes amputation was likely, due to her age and multiple medical problems.

The Director of Nursing (DON) was interviewed on 3/4/16 at 8:58 AM. The DON stated if a resident had a change in condition, the expectation was for nurses to call the physician. She added if a consultant physician could not be contacted, the PCP should be called. The DON stated if blood was seen, she expected nurses to contact a physician. The DON stated on 1/4/16, when the CM notified the surgeon of Resident #54 ' s fall, she would have expected her to provide notification of the bleeding and would have expected the nurses to call the PCP back or send the resident to the hospital for evaluation. The DON added she expected the CM to have resolution for the resident ' s change in condition prior to leaving the facility for the day and would not have expected staff to delay Resident #56 ' s treatment by almost 24 hours. The DON stated due to the resident ' s recent surgery, past medical history and her co-morbidities, she did not think the delay in treatment had been responsible for the amputation of the resident ' s right lower extremity.

A telephone interview was held with Nurse #4 on 3/4/16 at 9:30 AM. Nurse #4 stated he had worked on 1/4/16 and cared for Resident #56. He added Resident #56 had fallen prior to his arrival for the 3-11 shift. The nurse added while he assessed the resident's circulation in her right leg, he did not see any bleeding. The nurse added he had not received any information about bleeding in report from the 7 to 3 shift nurse and at no time had he been instructed to continue trying to contact the surgeon or the PCP. Nurse

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F 309	Continued From page 15 #4 stated he had not tried to call the surgeon or the PCP since he assumed that had been completed on the 7 to 3 shift. Nursing Assistant (NA) #3 was interviewed on 3/4/16 at 10:43 AM. The NA stated she had been assigned to care for Resident #56 on 1/4/16 when she fell during the 7 to 3 shift. The NA stated Resident #56 had tried to get out of bed independently before, but her room-mate typically notified staff. On 1/4/16, Resident #56's room-mate was not in the room. The NA stated she found Resident #56 in s sitting position on the floor with her right leg under her. She stated after Resident #56 was assessed and placed in bed, she had seen a red area on the side of her soft cast over where her stitches were that was approximately 2 inches by 2 inches. The NA stated prior to the fall on 1/4/16, she had not noticed any bleeding or drainage on the soft cast. The NA stated she had also worked with the resident on 1/5/16, but could not remember if there had been increased bleeding on the soft cast.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record	F 323		

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F 323	Continued From page 17 impairment and an unsteady gait along with unsafe mobility habits. Under Additional comments, the nurse documented a low bed and the falling leaf program (a facility program to identify residents at risk for falls) were initiated. The 1/5/16 Admission Minimum Data Set (MDS) indicated Resident #56 was assessed with short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The resident was coded as requiring extensive assistance for bed mobility and total assistance for transfers. Resident #56 was identified on the MDS as having a fall prior to admission, fracture related to a fall prior to admission and falls since admission with a non-major injury. Review of a Fall Investigation Assessment, dated 2/6/16 at 8:00 AM, and completed by Nurse #5, failed to include any information about the cause of the fall, what the resident was doing at the time of the fall or where the resident was found. The assessment indicated prior to the fall, Resident #56 used a fall mat, bed/chair alarm and pressure alarm on a low bed. The intervention added by Nurse #5 was the falling leaf program for 30 days. Review of nurse's notes for 2/6/16, revealed Nurse #5 had made no entry related to the resident's fall. Attempts to interview Nurse #5 were unsuccessful. Review of nurse's notes for 2/7/16 at 10:00 AM revealed Resident #56 sustained a fall. Staff were called to the room by the resident's room-mate. The Fall Investigation Assessment, dated for 2/7/16, revealed the resident was getting out of bed at the time of the fall. The assessment indicated the resident had been incontinent of bowel and bladder at the time of the fall. Under additional comments, the nurse had written, " use fall mat. "	F 323	**F – 323 Free of Accidents Hazards/Supervision Devices** **1. Resident #56 currently resides at facility. The staff involved received education on the Fall Risk assessments and appropriate interventions.** **2. All residents identified, at risk for falls, have the potential to be affected. The Falls Risk Assessment tool to be recompleted on those residents and implement new interventions, if appropriate along with care plans updated to reflect those changes made.** **3. All licensed staff to be educated on how to investigate and complete a falls report, steps in documentation, notification along with initiation of an appropriate new intervention. Staff educated regarding the falls protocol and those items used as at risk fall identifiers.** **4. DON or designee will review all reports and required charting completed and document findings. SDC will conduct random audits (in the form of a written quiz) 5 per week regarding the falls protocol and those items used as at risk fall identifiers, for the next 4 weeks then monthly. The DON will report these findings to the QAPI meeting for the next 2 quarters for review and any recommendations.** **5. Date of Compliance April 9, 2016**	

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F 323	Continued From page 18 Nurse #2 was interviewed on 3/3/16 at 9:24 AM. The nurse stated if, on admission, a resident was assessed as high risk for a fall, immediate interventions placed included a yellow arm band to identify the resident as a fall risk, a leaf outside the door and a bed or chair alarm. The nurse added chair/bed alarms were placed for confused residents that were a high risk for falls. Nurse #2 also added staff were told to keep the bed in a low position for residents that were fall risks. Nurse #2 acknowledged on 1/4/16, when Resident #56 fell, she had been on a low bed, had non-skid socks on and was wearing a tab alarm. On 3/3/16 at 11:51 AM, Nurse #3 was interviewed. The nurse stated when a resident fell, the expectation was for the nurse to assess for injury, complete vital signs, notify the physician and the responsible party, note the fall in the nurse's notes, monitor the resident for 72 hours and update the care plan with a new intervention. Nurse #3 stated she was unsure what fall protocol included that was initiated when a resident was assessed as a high risk of falls on admission. NA #1 was interviewed on 3/3/16 at 1:33 PM. She stated sometimes you could look at a resident and knew if they were at risk of falls. Additionally, the NA stated residents at risk for falls wore a purple band on the arm that signified a high fall risk. NA #1 added at other times, the nurse would tell her what residents were a high fall risk. The NA stated she was not aware what was included in the fall risk protocol. Resident #56's Responsible Party (RP) was interviewed on 3/3/16 at 1:59 PM. He stated prior to the resident's 1/4/16 fall he had notified staff the resident was a fall risk and was trying to get out of bed. He stated prior to her 1/4/16 fall, the	F 323		

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F 323	Continued From page 19 resident's bed was not kept in a low position and fall mats were not used. The RP was unable to recall the name of the staff person notified. NA #2 was interviewed on 3/3/16 at 2:34 PM. The NA stated a yellow arm band was used to identify residents at risk for falling. Additionally, a falling leaf was posted on the door of the resident's room. She stated immediate interventions used for residents at risk for falls included a low bed. ON 3/3/16 at 2:44 PM, NA #4 was interviewed. She stated the fall prevention protocol meant the resident received around the clock checks and were watched carefully. NA #4 stated all items that may be used by the resident were kept within reach. The Director of Nursing (DON) was interviewed on 3/4/16 at 8:58 AM. The DON stated after a resident fell, nurses were expected to assess, notify the physician and RP, document in the nurse's notes what had happened and place new interventions as well as completing an incident report. The DON stated it was her expectation for new interventions to be placed after each fall. The DON reviewed Resident #56's 1/4/16 fall and stated interventions added were a low bed and inclusion in the facility's falling leaf program. She reviewed the incident report for 2/6/16 at acknowledged there was no description of what happened or where the resident was found. The DON reviewed nurse's notes and acknowledged there was no nurse's note describing the incident. She added the facility would be unable to determine the root cause of Resident #56's 2/6/16 fall without information about how the fall occurred. The DON added after review of the 2/7/16 incident report there had been no new interventions added to prevent Resident #56 from falling again. An interview was held with the MDS nurse on	F 323		

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F 323	Continued From page 20 3/4/16 at 10:15 AM. She stated when a resident was admitted and assessed as a high risk for falls, the immediate intervention placed to prevent falls was a low bed. If an actual fall occurred, a falling leaf was placed on the resident's door for 30 days. The MDS nurse also added residents at a risk for falls were given a red arm band. She added the facility had no formal fall committee; adding administrative nurses reviewed falls daily to determine the root cause and to place appropriate interventions. The MDS nurse stated after a resident fell, nurses were expected to complete a nurse's note and an incident report that included how the resident was found, what had happened and a resident interview if appropriate. She stated this information was needed in order to determine and appropriate intervention. New interventions, the MDS nurse stated, was to be added after each fall. On 3/4/16 at 10:43 AM, NA #3 was interviewed. NA #3 validated she had worked with Resident #56 on 1/4/16 when she had a fall. The NA added Resident #56 had been found on the floor in a sitting position with her right leg underneath. Prior to the fall, the NA stated fall prevention interventions in place for Resident #56 included a low bed because the resident tried to get out of bed and a fall mat next to the bed. The NA stated when a resident was on the facility's fall prevention protocol, they received hourly checks. She added residents also wore arm bands, but she was unsure of the color and had a falling leaf placed on their door. NA #3 stated to the best of her knowledge, Resident #56 had only sustained the one fall on 1/4/16.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 21 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. 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. 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. The facility must provide separately locked, 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. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep medications secure by leaving 2 of 4 unattended medication carts	F 431	F- Tag 431 Drug Records Labels/Store Drugs and Biologicals 1. No specific residents were affected by this event. Staff involved were re-educated on proper security of med cart. 2. All residents have the potential to be affected. All Licensed Nurses to be educated to the proper way of securing a med-cart. 3. The Med Pass In-service to be conducted for all LPNs and RNs. Included in the education will be a review of medication storage and proper security for the medication cart when unattended. 4. The SDC or designee will conduct 2 random audits per week for medication cart security and document findings. The DON will report these findings at the QAPI meeting for 2 quarters for review and any recommendations. 5. Date of Compliance April 9, 2016	

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F 431	Continued From page 22 unlocked during medication pass observation. Findings included: 1a. On 3/02/2016 at 8:16 AM medication pass was observed with Nurse #6. The nurse left the cart unlocked in the hallway and entered room #209B. The resident's bed was positioned so that the nurse turned her back to the door to assist the resident to take the medication. An interview with Nurse #6 was conducted when the nurse exited the room. The nurse stated they were allowed to keep the medication cart unlocked if the medication cart if the nurse is nearby. On 3/02/2016 at 8:30 medication pass was observed with Nurse #6. The nurse left the cart unlocked in the hallway and entered room #206B. The privacy curtain had been pulled around the resident's bed, the nurse went behind the curtain to administer the medication to the resident. The resident's roommate had been observed ambulating in the room and staff had been observed in the hallway carrying breakfast trays to the cart at the end of the hall. The nurse then carried a breakfast tray from the room to a cart at the end of the hall. An interview with Nurse #6 was conducted when the nurse returned to the medication cart. The nurse stated she had gone behind the resident's curtain and the unlocked medication cart had been out of her sight during that time. The nurse stated the medication cart should be locked when it was out of her sight. b.On 3/02/2016 at 9:05 AM medication pass was observed with Nurse #2. The nurse left the cart unlocked near the doorway and entered room #103B. The resident's bed was positioned so that the nurse turned her back to the door to assist	F 431		

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F 431	Continued From page 23 the resident to take the medication. An interview was conducted with the nurse exiting the room. The nurse stated they were allowed to leave the medication cart unlocked if the medication cart was in the resident's room doorway. An interview with the Director of Nursing (DON) was conducted on 3/03/16 at 1:55 PM. The DON stated it would be her expectation of the nurse to lock the medication cart when the nurse steps away or does not have visual contact with the medication cart. The DON stated when the nurse had gone behind the privacy curtain the medication cart was no longer within view and should have been locked.	F 431	F-441 Infection Control, Prevent Spread, Linens 1. No specific residents were affected by this identified event. The nurse involved was reeducated to the proper procedure. 2. All residents requiring a blood sugar have the potential to be affected. All licensed nurses educated to the proper cleaning technique and appropriate supplies. 3. All licensed staff and support staff to be in serviced, on the proper cleaning of blood glucose machines after resident use with and without isolation precautions. 4. The Clinical Managers or designees will conduct weekly rounds to ensure proper technique is being followed with direct observation of 3 staff and document findings on rounding sheets. The DON will report these findings at QAPI for 2 quarters for review and or recommendations. 5. Date of Compliance April 9, 2016	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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F 441	Continued From page 24 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff and the product representative and review of product information, the facility failed to disinfect a blood glucose meter after use per manufacturer ' s specification for 1 of 1 sampled resident (Resident #11) diagnosed with clostridium difficile (C.difficile). Findings included: Resident #11 had been admitted to the facility on 2/26/16 with diagnoses that included C. difficile. An observation was made on 3/2/16 at 4:25 PM. A sign was observed on Resident #11's noted contact isolation and personal protective equipment was observed placed on a rack that hung on the door. Nurse #1 entered the resident's room to check his blood sugar. The nurse wore an isolation gown and gloves into the room. She took the glucometer into the room and placed it on the resident's over bed table. After wiping the resident's finger with alcohol, she used the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	C 03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 25 glucometer and checked Resident #11's blood sugar. After completing the blood glucose test, Nurse #1 placed the glucometer back on the resident's over bed table. While wearing her gloves and gown, the nurse went to the door of the resident's room and placed the glucometer on top of her medication cart. After removing her gown, gloves and washing her hands, Nurse #1 used a sanitizing wipe to clean the glucometer. At this time, during interview with Nurse #1, she stated Resident #11 had C. difficile. She added she was unaware if the sanitizing wipes she used to clean the glucometer was effective against C. difficile. At this time, the nurse reviewed the label for the wipes and acknowledged C. difficile was not listed as an organism killed by the sanitizing cloths. The manufacturer of the sanitizing wipes was called using the customer service number provided on the side of the sanitizing wipes on 3/2/16 at 4:28 PM. The representative stated the sanitizing wipes used by Nurse #1 was an alcohol based product that was not effective against C. difficile. She added in order to kill the C. difficile bacteria, a bleach based product must be used. An interview was held with the Director of Nursing on 3/2/16 at 4:30 PM who reviewed the label of the sanitizing wipes used by Nurse #1 and stated she did not see C. difficile documented as an organism the product killed.	F 441		