STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	04/07/2016

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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD P O BOX 708 BISCOE, NC 27209

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate 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 staff interview and record review the facility failed to accurately code Preadmission Screening and Resident Review (PASRR) on the Comprehensive Minimum Data Set (MDS) assessment for 1 of 1 residents (Resident #5) reviewed for PASRR, failed to accurately code the	F 278	Steps taken in regards to those residents found to have been affected: - PASRR number for resident #5 was coded to MDS on 4/7/16 - Anti-Depressant for resident #179 was coded to MDS on 4/7/16	4/26/16

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

Electronically Signed | 04/20/2016

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F 278	Continued From page 1 MDS for antidepressant medication and for depression for 1 of 19 sampled residents (Resident #179) failed to accurately code the MDS for End Stage Renal Disease for 1 of 19 sampled residents (Resident #99) and failed to accurately code the MDS for dental problems for 1 of 19 sampled residents (Resident #163). The findings included: 1. Resident #5 was admitted 11/20/15 with diagnoses including depressive disorder, delusional disorder, anxiety and malignant neoplasm. Review of the Medical Record revealed Resident #5 had a Preadmission Screening and Resident Review (PASRR) Level II (Level 2) number, _____ B, dated 6/2/14 with no expiration date. Review of the Significant Change Minimum Data Set (MDS) dated 11/27/15 revealed that in the PASRR section the answer to the following question was incorrectly coded as No: " Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition? On 4/7/16 at 9:21 AM interview with the MDS Coordinator #2 revealed that she had been the MDS Coordinator that completed the 11/27/15 MDS for Resident #5. She acknowledged that the MDS was incorrectly coded and stated that it was an oversight error. She added that she would correct the error and that the MDS should be accurately coded. 2. Resident # 179 was admitted to the facility on 2/12/16 and readmitted on 3/4/16 with multiple diagnoses including a history of cerebral	F 278	- End Stage Renal disease for resident #99 was coded to MDS on 4/20/2016 - On 4/7/16 Resident #163 was asked by Social Worker if they would like a dental appointment scheduled. On 4/17/16 resident #163 declined scheduling of a dental appointment. Steps taken in regard to those residents having the potential to be affected: - MDS Coordinator #1 conducted an audit on 4/7/16 on all residents to ensure every resident had the appropriate PASRR number. -Two resident assessments were modified by MDS Coordinator #1 to indicate a level PASRR - MDS Coordinator #1 completed an audit on 4/14 on all residents to ensure all psychotropic medications were coded correctly. -One resident assessment was modified by MDS Coordinator #1 to indicate a diagnosis of manic depression - MDS Coordinator #1 conducted an audit on 4/14 on all hemodialysis residents to ensure the diagnosis of End Stage Renal disease is included in their MDS assessment. -All residents with a diagnosis of End Stage Renal Disease had this ranked as diagnosis secondary #1 so that it will be indicated on all assessments. - Facility conducted an audit on 4/14 by MDS Coordinator #1 and MDS Coordinator #2 of all resident□s latest assessment to ensure the nursing documentation correlates to what is coded in the MDS assessment regarding oral	

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F 278	Continued From page 2 infarction, hemiplegia and aphasia. A review of the Physician Orders revealed an order dated 3/4/16 which stated Fluoxetine Hydrochloride 20 milligrams. Give 1 capsule by mouth one time a day for depression. A review of the Minimum Data Set (MDS) dated 3/30/16 revealed Resident # 179 was not assessed with the use of an antidepressant medication. A review of the Medication Administration Record (MAR) dated March 2016 revealed Resident #179 received Fluoxetine Hydrochloride 20 milligrams 1 capsule by mouth one time a day for depression from 3/5/16 to 3/31/16. An interview was conducted with MDS Nurse #1 on 4/7/16 at 8:55 AM. The Nurse stated she reviewed the MAR dated March 2016 to complete the MDS dated 3/30/16. The Nurse stated she did not assess the resident with the use of an antidepressant medication on the MDS dated 3/30/16. The Nurse stated the mistake was due to an oversight. An interview was conducted with the Director of Nursing (DON) on 4/7/16 at 9:45 AM. The DON stated she expected the MDS Nurse to correctly assess the resident with the use of an antidepressant medication on the MDS dated 3/30/16. 3. Resident # 179 was admitted to the facility on 2/12/16 and readmitted on 3/4/16 with multiple diagnoses including a history of cerebral infarction, hemiplegia and aphasia.	F 278	status. Measures put into place to ensure deficient practice does not recur: - Admissions coordinator or designee will indicate if a resident is a level II PASRR in the resident□s care profile. MDS will refer to this to ensure the proper level PASRR is coded - The MDS coordinators will audit 5% of all MDS assessments weekly before transmitting to ensure accurate coding of assessments. MDS#1 will audit MDS#2 assessments before transmittal. MDS#2 will audit MDS#1 assessments before transmittal. This audit will occur weekly for 8 weeks then monthly for four months. - The MDS coordinators will audit all hemodialysis resident assessments to ensure End Stage Renal disease has been coded. The will be conducted weekly before transmitting. This audit will occur weekly for 8 weeks then monthly for four months. How facility plans to monitor effectiveness of corrective action: Audits and PoC will be brought by MDS coordinator #1 or #2 to the Quality Assurance Committee for review. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	

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F 278	Continued From page 3	F 278		

A review of the Physician Orders revealed an order dated 3/4/16 which stated Fluoxetine Hydrochloride 20 milligrams. Give 1 capsule by mouth one time a day for depression.

A review of the Minimum Data Set (MDS) dated 3/30/16 revealed Resident #179 was not assessed with the diagnosis of depression.

A review of the Medication Administration Record dated March 2016 revealed Resident #179 received Fluoxetine Hydrochloride 20 milligrams 1 capsule by mouth one time a day for depression from 3/5/16 to 3/31/16.

An interview was conducted with MDS Nurse #1 on 4/7/16 at 8:55 AM. The Nurse stated she reviewed the MAR dated March 2016 to complete the MDS dated 3/30/16. The Nurse stated she did not assess Resident # 179 with the diagnosis of depression on the MDS dated 3/30/16. The Nurse stated the mistake was due to an oversight.

An interview was conducted with the Director of Nursing (DON) on 4/7/16 at 9:45 AM. The DON stated she expected the MDS Nurse to correctly assess the resident with the diagnosis of depression on the MDS dated 3/30/16.

4. Resident #99 was admitted to the facility 8/15/13. Cumulative diagnoses included end stage renal disease. Resident #99 was on hemodialysis three times weekly.

A Quarterly Minimum Data Set (MDS) dated

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3/7/16 was reviewed. End stage renal disease was not indicated on the active diagnosis section. Dialysis was marked yes as having been received during the assessment period.

On 4/07/2016 at 9:20AM, an interview was conducted with MDSnurse #2. She stated she should have coded end stage renal disease on the MDS. She failed to do that and it was a human error.

5. Resident #163 was admitted to the facility on 11/7/15. Cumulative diagnoses included chronic kidney disease and metabolic encephalopathy (abnormalities of the water, electrolytes, vitamins and other chemicals that adversely affect brain function).

A nursing admission assessment dated 11/7/15 indicated Resident #163 had her own teeth (had 3 teeth).

An Admission Minimum Data Set (MDS) assessment dated 11/14/15 indicated Resident #163 was cognitively intact. The oral/ dental status indicated " no " to any dental problems. Obvious or likely cavity or broken natural teeth was not checked. Dental care was not triggered.

A Quarterly MDS dated 3/25/16 indicated Resident #163 was cognitively intact. The oral/ dental status indicated "no" to any dental problems. Obvious or likely cavity or broken natural teeth was not checked.

On 4/4/16 at 3:26PM, an observation of Resident #163 was done during the stage one interview. Resident #163 had some broken teeth, missing teeth on bottom. Resident ' s top oral area was

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F 278	Continued From page 5 unable to be visualized. On 4/7/16 at 11:36AM, MDS nurse #2 stated she usually obtained her information from the dietary assessment. She reviewed the dietary assessment which stated Resident #163 had some missing and natural teeth. She stated she just missed it and it should have been documented on the MDS.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to review and revise	F 280	Steps taken in regards to those residents found to have been affected:	4/26/16

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F 280	Continued From page 6 the care plan for shunt site location and failed to revise the resident care guide to reflect shunt site, not to take blood pressure in shunt site arm and 1000 cubic centimeters (cc) fluid restriction for one of one residents reviewed for dialysis (Resident #99). The findings included: 1. a. Resident #99 was admitted to the facility on 8/15/13. Cumulative diagnoses included end stage renal disease and dialysis. A Quarterly Minimum Data Set (MDS) dated 3/7/16 indicated Resident #99 was cognitively intact. He was independent with eating. Dialysis was marked "yes" . A care plan dated 3/4/16 stated Resident #99 received dialysis treatments three times weekly due to end stage renal disease. Interventions included, in part: Monitor shunt/vascular catheter site for bleeding or signs/ symptoms of infection. No labs/blood pressure on shunt arm. The care plan did not indicate that Resident #99 had a dialysis shunt in the left upper arm area. Resident #99 did not have a vascular catheter. On 4/4/16 at 4:44pm, an interview was conducted with Resident #99. He stated he had a shunt in his left upper arm. He said the staff at the facility did not check his shunt site daily but he had no problems with the shunt site. An observation of Resident #99 revealed a shunt was present in the left upper arm without signs of infection/ redness/ swelling. On 4/7/16 at 9:00AM, an interview was conducted with the Director of Nursing. She stated information regarding the dialysis shunt site should be documented on Resident #99's care	F 280	- Care plan updated by MDS Coordinator #1 for resident #99 on 4/7/2016 to indicate No blood pressure in left upper extremity. - Care plan updated by MDS Coordinator #1for resident #99 on 4/7/2016 to indicate fluid restrictions - Kardex updated on 4/7/2016 by MDS Coordinator #1 to indicate fluid restrictions and which arm to obtain blood pressure from. Steps taken in regards to those residents having the potential to be affected: - MDS Coordinator #1 audited all other Dialysis residents to ensure care plan indicated both the correct arm to obtain blood pressure from and fluid restrictions on 4/8. o Three other hemodialysis residents did not have specifications as to which arm to obtain BP from and fluid restrictions. These care plans were updated on 4/6 and 4/7 by MDS Coordinator #1 and D.O.N. Measures put into place to ensure deficient practice does not recur: - Bruit and Thrill assessment will be initiated upon admission and be completed every shift by nursing. This will be documented on the Electronic Medication Administration Record in in the Electronic Health Record. - D.O.N. and MDS Coordinator updated Kardex on 4/6 and 4/7 to indicate fluid restrictions and proper arm to obtain blood pressure from. - D.O.N., A.D.O.N. and Staff Development in-serviced all nursing staff and CNAs,	

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F 280	Continued From page 7 plan. On 4/7/2016 at 9:20AM, an interview was conducted with MDS nurse #2 who stated the location of the shunt site should have been noted on the care plan. 1. b. Resident #99 was admitted to the facility on 8/15/13. Cumulative diagnoses included end stage renal disease and dialysis. A Quarterly Minimum Data Set (MDS) dated 3/7/16 indicated Resident #99 was cognitively intact. He was independent with eating. Dialysis was marked "yes" . A review of the Resident Care Guide dated 1/1/16 was reviewed. There was no information on the Resident Care guide used by the nursing assistants when they provided care for Resident #99 that indicated Resident #99 had a dialysis shunt in his left upper arm, not to take his blood pressure on his left upper arm or that Resident #99 had a fluid restriction of 1000 cc/day. On 4/4/16 at 4:44PM, an interview was conducted with Resident #99. He stated he had a shunt in his left upper arm. Resident #99 stated he was aware he should not drink a lot of fluids although he was not sure of the exact amount of fluids he should consume and he stated he told staff not to take any blood pressure in his left arm. On 4/7/16 at 8:15AM, an interview was conducted with NA#1. She stated she normally provided care for Resident #99 during the 7:00AM-3:00PM shift. She stated she was not aware of any type of restrictions other than not giving him any milk. NA#1 stated his diet slip stated fluid restriction	F 280	including weekend and prn staff, on 4/19, 4/20, 4/25 an 4/26 regarding fluid restrictions and obtaining blood pressure from proper arm. How facility plans to monitor effectiveness of corrective action: - Spot checks will be conducted by the Administrator, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator daily for two weeks then weekly for two months. The checks will include observing staff to ensure staff is obtaining blood pressure correctly and that fluid restrictions are being followed. These checks will be recorded on the BP & Fluid Restriction audit forms. - Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or nursing supervisor will audit all admissions to ensure the Kardex has been updated and the Bruit and Thrill assessment has been initiated. This audit will be completed indefinitely. - Audits and PoC will be brought by the D.O.N., A.D.O.N. or Staff Development Coordinator to the Quality Assurance Committee for review. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	

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F 280	Continued From page 8 but she did not know the amount of the fluid restriction. She also stated she knew Resident #99 went to dialysis and she should not take any blood pressure in the arm that had the dialysis shunt but she did not know which arm had the shunt. NA #1 stated she learned what to do for Resident #99 from the information that was on the Resident Care Guide that was posted in his closet. NA#1 reviewed the Resident Care Guide that was posted in the closet and stated there was nothing written about his shunt, fluid restriction or which arm she should not take his blood pressure. On 4/7/16 at 9:00AM, an interview was conducted with the Director of Nursing. She stated information regarding the dialysis shunt site, fluid restriction and not taking the blood pressure in the left arm should have been documented on Resident #99's Resident Care Guide. On 4/7/2016 at 9:20AM, an interview was conducted with MDS nurse #2 who stated the location of the shunt site, not to take blood pressure in that arm and the 1000 cc fluid restriction should have been included on the Resident Care Guide for the nursing assistants.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation, the facility failed to transcribe	F 281	Steps taken in regards to those residents found to have been affected:	4/26/16

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F 281	Continued From page 9 physician orders related to palliative care for one of one resident (Resident #52) reviewed for palliative care and failed to transcribe physician orders for wound care and to accurately document treatment on the Treatment Administration Record (TAR) for one of three residents (Resident #29) reviewed for pressure ulcers. The findings included: 1. Resident #52 was admitted to the facility on 7/26/10 with multiple diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment indicated she had significant cognitive impairment. On 4/4/16 the facility provided a list of residents who were on comfort care/end of life care. Resident #52 was included on the list. A Patient's at Risk (PAR) committee nursing note on 3/10/16 indicated palliative care measures were in place for Resident #52. A PAR committee nursing note on 3/17/16 indicated Resident #52 remained on palliative care. A PAR committee nursing note on 3/30/16 indicated palliative care measures were in place as per family request for Resident #52. A review of the physician's orders for March 2016 and April 2016 revealed there was not a physician's order that indicated no hospitalizations for Resident #52. The physician's orders also revealed there was not a physician's order to change oral medications to liquids or IV (if unable to swallow), or IVF only if physician thought it was beneficial for Resident	F 281	- Active palliative care orders were transcribed for resident #52 4/6/2016 - Current treatment orders were transcribed for resident #29 on 4/5/2106 Steps taken in regards to those residents having the potential to be affected: - All palliative and treatment orders were audited by the Assistant Director of Nursing for accuracy and completeness for all residents on 4/8. All orders were transcribed correctly. - D.O.N., A.D.O.N and Staff Development Coordinator in-serviced licensed nurses on 4/20 and 4/25 regarding transcribing orders. Measures put into place to ensure deficient practice does not recur: - Progress notes from wound MD are given to nursing staff by the Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator on Tuesday following the wound MD visit on Monday. Any orders that need to be initiated that Monday will be initiated by the nurse making rounds with the wound MD. All treatment orders will be audited for accuracy and completeness. All orders are written on order form. Order form is audited by an additional two nurses before order is initiated. These audits will continue indefinitely - All palliative orders will be reviewed by the care plan team and audited by the facility MDS coordinator. These audits will occur indefinitely. How facility plans to monitor effectiveness	

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F 281	Continued From page 10 #52. An interview was conducted on 4/6/16 at 3:25 PM with Nurse #5. Nurse #5 indicated Resident #52 was not receiving palliative care. An interview was conducted on 4/6/16 at 3:26 PM with Nurse #6. Nurse #6 indicated Resident #52 was receiving palliative care. Nurse #6 reviewed the facility's normal process for a resident receiving palliative care. She stated palliative care was different for every resident. She continued by stating there was a care plan meeting held with the resident and/or family to discuss their wishes. She indicated the resident's and/or family's wishes was what the facility considered palliative care. She stated that after the care plan meeting the resident's and/or family's wishes are reviewed with the physician for approval and then the orders are written. This process was reviewed for Resident #52. The care plan conference note from 5/7/14 was reviewed with Nurse #6. She indicated that was when Resident #52 initially was placed on palliative care and had continued on palliative care since that time. She stated the family's palliative care wishes for Resident #52 included DNR, no hospitalizations, change oral medications to liquids or IV if Resident #52 was unable to swallow, and IVF only if physician thought it was beneficial. The orders from 5/8/14 were reviewed with Nurse #6. These orders reflected the family of Resident #52's wishes for palliative care as expressed in the care plan conference on 5/7/14. The interview with Nurse #6 continued. The March 2016 and April 2016 physician's orders for Resident #52 were reviewed. Nurse #6 revealed	F 281	of corrective action: Audits and PoC will be brought by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator to the Quality Assurance Committee for review. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	

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there was not a physician's order that indicated no hospitalizations for Resident #52. She additionally revealed there was not a physician's order for IVF only if physician thought it was beneficial for Resident #52. She stated the facility had a standing order indicating the ability to change oral medications to liquid or IV if needed. Nurse #6 indicated the facility changed Electronic Medical Record (EMR) systems on March 1, 2016. She stated the orders were transcribed to the new EMR system by staff manually. She revealed these orders were not transcribed to the new system. She indicated that was a mistake. She stated multiple staff were responsible for transcribing the orders. She indicated a different staff member then double checked the orders. She revealed both staff who participated in the transcription of physician orders from the previous EMR system to the new EMR system for Resident #52 had over looked these physician's orders. She indicated that a nurse who was not familiar with Resident #52 would not have been aware of these orders. She stated the family was always contacted when there was a change in condition and she believed the family would have alerted staff members of their wishes had there been a change in condition with Resident #52. She acknowledged that emergency situations sometimes occurred and the family was not always able to be reached. She indicated this had not occurred for Resident #52. She stated she was going to contact the physician and add the orders in that day (4/6/16).

An interview was conducted on 4/6/16 at 3:35 PM with Nurse #5. Nurse #5 revealed she was not aware of the orders for no hospitalizations and IVF only if physician thought it was beneficial for Resident #52. She stated the facility had a

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F 281	Continued From page 12 standing order indicating the ability to change oral medications to liquid or IV if needed. An interview was conducted on 4/6/16 at 4:20 PM with the Director of Nursing (DON). She stated the facility transitioned to a new EMR system on March 1, 2016. She indicated multiple staff were involved in transcribing physician's order from the previous EMR system to the new EMR system. She stated her expectation was for all orders to be transcribed to the new EMR system. The DON indicated Resident #52 was receiving palliative care. She revealed all physician's orders related to palliative care should have been transcribed to the new EMR system as of March 1, 2016. A physician's order for Resident #52 initiated on 4/6/16 indicated facility may change oral medications to liquid or IV if Resident #52 was unable to swallow, IVF only if physician thought it was beneficial, and no hospitalization. 2. Resident #29 was admitted 10/31/13 with cumulative diagnoses including diabetes, chronic kidney disease and polyneuropathy. Review of the Quarterly Minimum Data Set (MDS) dated 1/5/16 revealed Resident #29 was cognitively intact and had no unhealed pressure ulcers. A Weekly Wound Assessment dated 3/19/16 revealed a stage 1 pressure ulcer on the resident ' s right heel. A Physician ' s Order dated 3/19/15 specified the following treatment for a pressure ulcer to the resident ' s Right heel: cleanse with (wound cleanser brand) apply (brand name for a	F 281		

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non-adhesive, foam wound dressing) and cover with (brand name of a gauze bandage roll) once daily and as needed.
A 3/21/16 Wound Care Specialist Evaluation dated 3/21/16 revealed the wound on the resident ' s right heel had become a Stage 2 pressure ulcer. Complicating factors included Diabetes Mellitus. The treatment specified was Leptospemum honey once daily.
A Weekly Wound Assessment dated 3/22/16 revealed " Continue Leptospermum honey qd (every day) " .
Review of the Physician ' s Orders from 3/19/16 - 3/22/16 revealed no new wound treatment orders; the order for a non-adhesive foam dressing was still active.
Review of the Treatment Administration Record revealed the treatment that was signed off as completed daily from 3/19/16 through 3/22/16 was the application of a non-adhesive foam dressing. There were no other treatments indicated as having been done for the resident ' s right heel pressure ulcer.
A Weekly Wound Care Specialist Evaluation dated 3/28/16 revealed the wound on the resident ' s right heel had become unstageable. The treatment plan specified that leptospermum honey was discontinued and betadine once daily was started.
A Weekly Wound Assessment dated 3/29/16 indicated that the treatment being done to the resident ' s right heel was " betadine dressing daily " .
Review of the Physician ' s Orders from 3/22/16 - 3/29/16 revealed no new wound treatment orders; the order for a non-adhesive foam dressing was still active.
Review of the Treatment Administration Record revealed the treatment that was signed off as

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completed daily from 3/22/16 through 3/29/16 was the application of a non-adhesive foam dressing. There were no other treatments indicated as having been done for the resident ' s right heel pressure ulcer.
A Weekly Wound Care Specialist Evaluation dated 4/4/16 revealed the wound on the resident ' s right heel was still unstageable. The treatment specified was betadine once daily.
A Weekly Wound Assessment dated 4/5/16 indicated the treatment being done to the resident ' s right heel was betadine dressing daily.
Review of the Physician ' s Orders from 3/29/16 - 4/5/16 reveled that on 4/5/16 the order for the non-adhesive foam dressing to the resident ' s right heel was discontinued and there was a new order dated 4/5/16: cleanse with wound cleanser apply betadine and wrap with gauze roll daily until healed.
On the Treatment Administration Record (TAR) the foam dressing treatment was discontinued on 4/5.16 and the betadine was initiated.
Observation of the dressing change to Resident #29 ' s right heel revealed the treatment being provided at that time was to cleanse the wound with wound cleanser, apply betadine and wrap with a gauze wound roll.
Interview with the Treatment Nurse on 4/7/16 at 11:00 AM revealed she had not been aware that the Wound Physician ' s orders had not been written and transcribed onto the TAR. She stated that she had not done any of the dressing changes for Resident #29 between 3/19/16 and 4/5/16 but had checked the dressing and had assisted the Wound Care Physician with his evaluations. She stated that on every observation the resident had the treatment as specified by the wound care physician and not the foam dressing as indicated on the TAR. The

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Treatment Nurse also said that the hall nurse was responsible for writing the physician orders for wound care based on his report which was available the day after his visit. She did not know why this had not been done but indicated the hall nurse should have written new orders and transcribed them to the TAR on 3/22/16 and 3/29/16.
Telephone Interview with Nurse #4 on 4/7/16 at 11:30 AM revealed that she recalled doing Resident #4 ' s dressing change on several occasions between 3/19/16 - 4/6/16. She indicated that she had never seen or used a foam dressing for the resident ' s right heel pressure ulcer and only recalled doing a betadine treatment. She stated she was unaware that she had signed off on the TAR that a foam dressing had been applied on the days she completed the treatment up to 4/5/16. Nurse #4 stated that the day after the Wound Doctor saw the resident his notes were available and the hall nurse was supposed to write any new orders as indicated in the Wound Care Physician report. She did not know why new orders for Resident #29 were missed until 4/5/16 but indicated the orders should have been changed previously according to the Wound Care Specialist Evaluation notes. She added that the treatment that had been provided was according to the wound physician ' s intended order and that treatments were incorrectly documented on the TAR.
Telephone Interview with Nurse #7 on 4/7/16 at 12:30 PM revealed that she recalled completing the resident ' s dressing change on several occasions between 3/19/16 and 4/5/16. She stated she had not been aware that the TAR indicated a foam dressing was to be applied and that she had only ever used betadine for the resident ' s wound dressing as best she could

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F 281	Continued From page 16 remember. Telephone Interview with the Wound Care Physician on 4/7/16 at 12:45 PM revealed that he did not recall any occasions where he came to see the resident and the dressing that had been applied to Resident ' s #29 ' s right heel pressure ulcer was a foam dressing. He said that as far as he recalled the wound appeared to be dressed according to the specifications in his Wound Care Specialist Evaluation note.	F 281		
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 record review, observation, and staff interview, the facility failed to identify an ongoing pattern of behavioral issues resulting in the failure to provide psychological interventions to address the behavioral issues for one of one resident (Resident #146) reviewed for behavioral and emotional status. The findings included: Resident #146 was admitted to the facility on 12/28/15 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 1/7/16 indicated Resident #146 had significant cognitive impairment, no physical behavioral symptoms, no verbal behavioral symptoms, and no rejection of	F 309	- Resident #146 was referred to mental health provider on 4/6. - Resident seen by mental health on 4/8. Steps taken in regard to those residents having the potential to be affected: - Director of Nursing and Social Worker reviewed behavior report on 4/8 to identify any other residents needing further evaluation of behaviors with no issues noted. - Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator in-serviced staff on 4/20 and	4/26/16

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F 309	Continued From page 17 care. The quarterly MDS assessment dated 3/15/16 indicated Resident #146 had an increase in physical behavioral symptoms, verbal behavioral symptoms, and rejection of care. Resident #146 was indicated to have physical behavioral symptoms 1-3 days, verbal behavioral symptoms 1-3 days, and rejection of care 1-3 days during the 7 day look back period of the 3/15/16 quarterly MDS assessment. The care plan dated 1/11/16 indicated the focus area of Behavior/Mood for Resident #146. The interventions included: attempt to determine cause of behavior, encourage to verbalize feelings, and monitor adjustment to placement. Nursing Assistant (NA) behavior documentation on 3/9/16 indicated Resident #146 had physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others. A nursing note on 3/9/16 indicated Resident #146's daughter was in to visit and voiced concerns of a change noted in resident. Vital signs were stable. The Nurse Practitioner (NP) evaluated Resident #146. New orders were noted for a Computerized Tomography (CT) scan without contrast to rule out Cerebrovascular Accident (CVA). A physician's order on 3/10/16 indicated a CT scan without contrast to rule out CVA for Resident #146. A physician's order on 3/10/16 indicated Robaxin (muscle relaxer) 500 milligrams (mg) as needed (PRN) for pain for 30 days to be given 1 hour prior to therapy. A nursing note on 3/11/16 indicated the CT scan was scheduled for Resident #146 on 3/15/16 at	F 309	4/25 regarding reporting any increased or abnormal behaviors to their nurse or their supervisor. Measures put into place to ensure deficient practice does not recur: - Social Worker will review behavior report daily, indefinitely. If report indicates any increased behaviors, this information will be relayed during risk round meeting. - Nursing staff was in-serviced by Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator on 4/20 and 4/25 regarding completing a referral form and submitting to the social worker if there are any new or increasing behaviors. How facility plans to monitor effectiveness of corrective action: - Behavior report will be reviewed daily in risk round meeting. Any referrals received by social worker will also be discussed daily is risk round meeting.	

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10:00 AM. Family was informed of the appointment.

A nursing note on 3/13/16 indicated Resident #146 had not tolerated the restorative program. She refused to complete the functions and had not cooperated with what needed to be done.

A nursing note on 3/15/16 indicated Resident #146 went to the hospital for a CT head scan.

A social services note on 3/15/16 indicated nursing had seen at least one time of physical and verbal abuse as they offered care to Resident #146.

A nursing note on 3/17/16 indicated the results of the CT were negative and no new orders were noted for Resident #146. The family was notified.

NA behavior documentation on 3/20/16 indicated Resident #146 had an episode of grabbing and pinching/scratching/spitting.

A plan of care note on 3/20/16 indicated Resident #146 had an episode of yelling. Staff redirected the behavior with somewhat effective results. Staff also spent one on one time with Resident #146.

NA behavior documentation on 3/21/16 indicated Resident #146 had an episode of grabbing.

A nursing note on 3/22/16 indicated Resident #146 refused to cooperate with restorative and staff care. It additionally indicated Resident #146 fought with staff when care was given.

NA behavior documentation on 3/23/16 indicated

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Resident #146 had an episode of grabbing.

A plan of care note on 3/23/16 indicated staff reported Resident #146 had a behavior and staff redirected resident with effective results. One on one time also spent with Resident #146.

NA behavior documentation on 3/24/16 indicated Resident #146 had an episode of grabbing.

NA behavior documentation on 3/25/16 indicated Resident #146 had an episode of grabbing.

A nursing note on 3/25/16 indicated the physician saw Resident #146 and new orders were noted to change robaxin 500mg from PRN to twice daily. The family was informed.

A physician's order on 3/25/16 for Resident #146 indicated robaxin 500mg twice daily for muscle. Robaxin 500mg for pain one hour prior to therapy for 30 days was discontinued.

NA behavior documentation on 3/27/16 indicated Resident #146 had an episode of grabbing, kicking/hitting, and rejection of care.

NA behavior documentation on 3/28/16 indicated Resident #146 had an episode of rejection of care.

NA behavior documentation on 3/29/16 indicated Resident #146 had an episode of grabbing.

A plan of care note on 3/29/16 indicated Resident #146 had an episode of yelling out and staff redirected the behavior with effective results.

NA behavior documentation on 4/1/16 indicated

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Resident #146 had an episode of grabbing.

NA behavior documentation on 4/3/16 indicated Resident #146 had an episode of grabbing.

A plan of care note on 4/3/16 indicated Resident #146 was uncooperative with the restorative program. Staff attempted to redirect her with somewhat effective results.

NA behavior documentation on 4/4/16 indicated Resident #146 had an episode of grabbing.

An observation of Resident #146 was conducted on 4/6/16 at 9:40 AM. Resident #146 was in her room in her wheelchair. There were no behaviors noted.

An interview was conducted on 4/6/16 at 9:46 AM with the Social Worker (SW). She indicated she expected to be informed of resident's behaviors by verbal communication if there was something new or unusual that was a concern. She stated she was responsible for coordinating psychological consultations/services for all residents and staff informed her if a referral was needed. She indicated she completed the section of the MDS that addressed behavioral symptoms. She stated she reviewed nursing notes and NA documentation if an MDS review was due, but she had not routinely reviewed nursing notes or NA documentation. She indicated on the facility's Electronic Medical Record (EMR) system there was a function titled "dashboard" that automatically alerted all staff members if a behavior was documented for a resident. She stated she was still learning to use all of the functions of the EMR system as the facility changed EMR systems as of 3/1/16.

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The interview with the SW continued. She stated she was familiar with Resident #146. The social services note from 3/15/16 was reviewed with the SW. She indicated she had written the note. She stated that note corresponded to the quarterly MDS from 3/15/16 that indicated Resident #146 had physical behavioral symptoms 1-3 days, verbal behavioral symptoms 1-3 days, and rejection of care 1-3 days during the 7 day look back period. She stated when she wrote the note on 3/15/16 she indicated Resident #146 had at least one episode of physical and verbal abuse when nursing staff offered care. She stated she probably thought the behaviors occurred only one time and was not a pattern of behaviors. She indicated Resident #146 had not exhibited physical or verbal behaviors prior to that time. She stated no new behavioral interventions were added at that time for Resident #146 as she believed the behaviors were isolated and were not a pattern. She revealed she had not been informed the behaviors were ongoing for Resident #146. The SW indicated she expected a nurse to inform her of an ongoing pattern of behaviors. She stated that had not happened for Resident #146. The NA behavior documentation was reviewed with the SW. She again indicated she was not aware Resident #146's behaviors were ongoing and that they had occurred so frequently. The SW revealed if she had been aware she would have looked at new behavioral interventions, she would have discussed a mental health referral with the family, and if the family was agreeable she would have completed a referral for a psychiatric consultation. The SW indicated she was going to speak to Resident #146's family that day (4/6/16) and would then complete a referral for a psychiatric consultation if

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they agreed.

An interview was conducted on 4/6/16 at 10:33 AM with NA #2. She indicated behaviors were documented by NAs on the kiosk. She stated if a resident had a behavior the NA was expected to document it on the kiosk and inform the nurse verbally. She indicated that all behaviors were expected to be reported verbally to the nurse whether it was a new behavior or an ongoing behavior.

An interview was conducted on 4/6/16 at 10:45 AM with Nurse #6. She indicated NAs documented behaviors for all residents on the kiosk. She stated NAs were also expected to report any behaviors to the nurse verbally. She indicated an alert was automatically received on their EMR system if an NA documented a behavior for a resident. She stated the alert was able to be seen on the EMR "dashboard" by all staff. She stated she checked the dashboard several times per day. She indicated if a staff member addressed the alert on the dashboard by documenting a note, the alert was automatically cleared off the dashboard. She stated if an alert appeared on a day she was not working and it had been addressed by another staff member prior to her next shift, she would not have been aware an alert occurred.

The interview with Nurse #6 continued. She stated she was familiar with Resident #146. She indicated she was aware Resident #146 had a few behaviors every now and then. Nurse #6 stated Resident #146 became tense sometimes and she had scratched at staff in the past. Nurse #6 reviewed the medical record. She indicated Resident #146 had a noted change in condition

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on 3/9/16. She stated on 3/10/16 the physician ordered a CT scan and also ordered robaxin PRN to help with Resident #146's tension. She indicated the CT scan was completed on 3/15/16 and the results were negative. Nurse #6 indicated the robaxin order for Resident #146 was changed from PRN to twice daily on 3/25/16. She stated she believed the robaxin helped to decrease Resident #146's tension and behaviors, but she revealed she was unaware the behaviors were exhibited frequently. The NA behavior documentation for Resident #146 was reviewed with Nurse #6. She reiterated that she was not aware the behaviors occurred frequently. She stated she had spoken with Resident #146's family about a week ago regarding the behaviors that she was aware. She indicated she thought it was a decline in condition due to Resident #146's dementia progression. Nurse #6 stated she had not documented the communication with Resident #146's family and she was unable to recall the exact date the conversation took place. She stated she had not shared that information with the SW. Nurse #6 revealed the Director of Nursing (DON) asked her to complete a facility communication form to be given to the physician to request an order for a psychiatric consultation around 10:00 AM that morning (4/6/16). She indicated she completed the form for Resident #146 and she was to be seen for a psychiatric consultation before the end of the week. Nurse #6 stated that was the first time a psychiatric consultation had been discussed for Resident #146.

A follow up interview was conducted with the SW on 4/6/16 at 11:00 AM. She indicated she spoke with Resident #146's family by phone and they were agreeable to a psychiatric consultation. She

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F 309	Continued From page 24 stated Resident #146 was to be seen for a psychiatric consultation by the end of the week. A social service note dated 4/6/16 indicated that due to increased behaviors a referral to mental health was made for Resident #146. The NP was made aware and the family was agreeable. Resident #146's care plan was updated on 4/6/16. Two focus areas were added: - Resident #146 had the potential to demonstrate physical behaviors due to dementia - Resident #146 was resistive to care due to dementia	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to prevent a stage 1 pressure ulcer (intact skin with non-blanchable redness) noted on admission from worsening to a stage 3 pressure ulcer (full thickness tissue loss) in one of three residents reviewed for pressure ulcers. The findings included:	F 314	Steps taken in regards to those residents found to have been affected: - Resident #184 was seen by wound MD on 4/4 - Repositioning of resident #184 was scheduled in the kiosks for completion by CNAs q care rounds - Daily dressing changes were initiated on	4/26/16

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F 314	Continued From page 25 Resident #184 was admitted to the facility 3/29/16. Cumulative diagnoses included Alzheimer ' s disease, functional quadriplegia, history of stage 4 sacral pressure ulcer and pressure ulcer to right lower back. A hospital discharge summary dated 3/29/16 indicated Resident #184 had a stage 1 pressure ulcer on her bottom. A review of nursing admission assessment note dated 3/29/16 stated Resident #184 had a reddened are noted on her coccyx. The admission assessment stated Resident #184 was not on a turning/repositioning program. A dietary admission/ readmission note dated 3/31/16 at 4:35PM stated Resident #184 had a stage 1 pressure ulcer on her right lower back. A biweekly skin assessment dated 3/29/16 indicated Resident #184 had a raw area noted on her coccyx. A protective barrier cream was applied. A biweekly skin assessment dated 3/30/16 indicated no current skin issues; no new identified skin issues. Physician orders were reviewed and revealed a physician ' s order dated 4/1/16 for a foam wound dressing to be applied to the sacrum daily. A 5day/admission Minimum Data Set (MDS) dated 4/2/16 was incomplete. Therefore, no information was available. A wound care physician ' s note dated 4/4/16	F 314	4/1. Steps taken in regard to those residents having the potential to be affected: - Repositioning has been scheduled on 4/6/2016 for all CNAs to complete on all residents needing assistance with bed mobility. The CNAs must sign off q shift that this has been completed. - The Kardex within the electronic health record has been updated to indicate that all CNAs must turn and reposition those who need assistance with bed mobility. - Director of Nursing and Assistant Director of Nursing completed an audit on 4/6 of all other wounds within the facility to assess and ensure that all appropriate interventions have been initiated. All interventions currently in place and no worsening pressure ulcers noted. Measures put into place to ensure deficient practice does not recur: - Facility will continue to monitor all wounds in weekly Patient at Risk meeting. - Facility will continue to complete skin assessments on admission, readmission and weekly. - Wound MD will continue to provide weekly wound assessment and treatment. - D.O.N., A.D.O.N and Staff Development Coordinator completed in-servicing with all licensed nurses, including weekend and prn, regarding the documentation of skin breakdown on 4/20, 4/25 and 4/26 - D.O.N., A.D.O.N and Staff Development Coordinator completed in-servicing with all CNAs, including weekend and prn, on 4/19, 4/20,4/25 and 4/26 regarding	

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F 314	Continued From page 26 stated Resident #184 had a wound on her sacrum of at least 6 days duration. The wound care physician stated Resident #184 had a history of a stage 4 sacral wound in the past. On 4/4/16, the area presented as a stage 3 pressure ulcer that measured.3.5 centimeters x 8.7 centimeters x 0.2 centimeters depth. The area had light serous drainage and had 20% thick adherent devitalized necrotic tissue (black tissue) and 30% granulation tissue. The wound was debrided (black tissue removed) and recommendations were noted for medi-honey and a foam dressing to be applied daily. A physician order dated 4/5/16 indicated to apply medi-honey with foam dressing to sacrum daily. On 4/6/16 at 10:40AM, wound care to the sacrum pressure ulcer was observed. Resident #184 had an open area on her sacrum that measured approximately 1 ½ inches in length and 1 inch wide. The tissue was pink in color with no drainage/ odor noted. Resident #184 was unable to answer any questions and was severely impaired in decision-making skills. Resident #184 was unable to turn and reposition herself and required staff assistance for turning and repositioning. Pressure ulcer care was performed per physician ' s orders. The nurse stated Resident #184 received a nutritional supplement four times daily via gastrostomy tube (tube in the abdomen that is used for nutritional supplementation) as well as eating by mouth. Resident #184 was on a pressure relief mattress. A care plan dated 4/5/16 stated Resident #184 had a history of a stage 4 pressure ulcer and currently had a pressure ulcer. Interventions included: facility skin protocol; notify physician of	F 314	repositioning. - Skin observations will be initiated upon admission and to be completed twice within the first 24 hours all residents are admitted to the facility. - A 72 hour post admission note will be initiated upon admission and completed q shift for 72 hours. How facility plans to monitor effectiveness of corrective action: - Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nursing Supervisor will complete a skin assessment on every admission within the first 72 hours. This audit will be completed to ensure complete and accurate documentation by the nursing staff. This audit will be completed for 3 months on every admission. - Audits and PoC will be brought by the D.O.N., A.D.O.N or Staff Development Coordinator to the Quality Assurance Committee for review. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	

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F 314	Continued From page 27	F 314		

changes in skin, incontinent care as needed. Wound consult as needed and treatment per physician orders. It was not documented that Resident #184 was on a turning/ repositioning program.

A review of the nursing notes and documentation completed by the nursing assistants was reviewed. There was no documentation noted regarding turning and repositioning of resident to relieve pressure to the sacrum/ coccyx area.

On 4/6/16 at 1:36PM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to do a complete head to toe assessment on admission which included a skin assessment with a description and measurements of pressure ulcer. A review of the medical record revealed no skin assessment with description and measurement of the sacral area was done on admission. The Director of Nursing also reviewed Resident #184 ' s medical record and did not find any documentation that Resident #184 had been placed on the turning and repositioning program.

On 4/6/16 at 3:49PM, an interview was conducted via telephone with nurse #2. She stated she was the nurse who admitted Resident #184 on 3/29/16. Nurse #2 stated Resident #184 only had a reddened area on her coccyx that was approximately the size of a quarter on the day of admission. She stated there was no broken skin area at that time and there was " nothing to be measured " .

On 4/6/16 at 4:25PM, a telephone interview was conducted with Nurse # 3. She stated she had completed the bi-weekly skin observation done

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F 314	Continued From page 28 on 3/30/16 and did not remember if there was any open sin areas at that time. She stated she thought the area was just reddened on 3/30/16 but was not sure of the size of the area.	F 314		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334		4/26/16

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F 334	Continued From page 29 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document in the resident's medical record that education regarding the benefit and potential side effects of the influenza vaccine and the pneumococcal	F 334	Steps taken in regards to those residents found to have been affected: Consent form was signed by Resident #75 □s son on 4/13/2016.	

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F 334	Continued From page 30 vaccine was provided to the resident or legal representative for two of five residents reviewed for flu/ pneumonia immunization (Resident #75 and #25). The findings included: 1. Resident #75 was admitted to the facility on 1/12/16. Cumulative diagnoses included renal insufficiency and diabetes. An Admission Minimum Data Set (MDS) dated 1/19/16 indicated Resident #75 was cognitively intact. It was documented that Resident #75 did not receive the influenza vaccine because it was medically contraindicated. A 30 day MDS dated 3/6/16 was reviewed and revealed that Resident #75 received the influenza vaccine outside of the facility. A review of the medical record revealed no documentation that Resident #75 had received any education regarding the benefit and potential side effects of the influenza vaccine or that Resident #75 had received the influenza vaccine outside of the facility or that it was medically contraindicated. The infection control nurse reviewed the facility records and could not find any documentation regarding the influenza vaccine for Resident #75. On 4/7/16 at 10:53AM, the Director of Nursing stated all residents should be offered the influenza and pneumococcal vaccine on admission, provided the educational material and documentation should be in the resident's medical record that the vaccines were offered. 2. Resident #25 was admitted to the facility on 9/2/13. Cumulative diagnoses included:	F 334	Consent form was signed by resident #25 on 4/20/2016. Steps taken in regard to those residents having the potential to be affected: Assistant Director of Nursing audited all residents on 4/8 to ensure proper immunization consent forms are signed. Pneumonia consents not uploaded to the electronic health record, D.O.N., A.D.O.N. and or Staff Development Coordinator will confirm consent with resident or responsible party by 4/26. Measures put into place to ensure deficient practice does not recur: - D.O.N., A.D.O.N and Staff Development Coordinator in-serviced licensed nurses, including weekend and prn, on 4/20, 4/25 and 4/26 to ensure that immunization records are signed upon admission by resident or responsible party. The immunization consent forms will continue to be signed upon admission. - For new admissions, the immunization consent forms will be given to the Assistant Director of Nursing to be included in the new admission audit. - All other immunization consent forms will be given to the A.D.O.N. The A.D.O.N. will retain copies of all consent forms until discharge. - After discharge these forms will then be filed in the resident□s record. A copy of the consent form will also be scanned into each resident□s EHR. How facility plans to monitor effectiveness of corrective action:	

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F 334	Continued From page 31 coronary artery disease, arthritis and hemiplegia. An Annual Minimum Data Set (MDS) dated 2/17/16 indicated Resident #25's short and long term memory was ok and she was moderately impaired in decision-making. The MDS indicated Resident #25 had received the pneumococcal vaccine. A review of the medical record revealed no documentation that Resident #25 had received any education regarding the benefit and potential side effects of the pneumococcal vaccine or had received the pneumococcal vaccine. The infection control nurse reviewed the facility records and could not find any documentation regarding the pneumococcal vaccine for Resident #25. On 4/7/16 at 10:53AM, the Director of Nursing stated all residents should be offered the influenza and pneumococcal vaccine on admission, provided the educational material and documentation should be in the resident's medical record that the vaccines were offered.	F 334	- Assistant Director of Nursing will continue to conduct admission audits to ensure the immunization consent form is signed. The Director of Nursing or Administrator will audit the A.D.O.N□s admission audit to ensure immunization consent form has been signed. This audit will be conducted by the D.O.N. or Administrator weekly for one month then monthly for 6 months. Corrective actions will also be evaluated by the Quality Assurance Committee. - Audits and PoC will be brought to the Quality Assurance Committee by the D.O.N., A.D.O.N or Staff Development Coordinator. Any area of continued concern will be brought back to the QA committee by the Administrator for further action plan.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431		4/26/16

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F 431	Continued From page 32 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 observation, manufacturer's instructions and staff interview, the facility failed to discard expired ophthalmic eye medication in one of one of 6 med carts (300 hall). The findings included: Manufacturer's instructions for latanaprost ophthalmic solution 0.005% state "STORAGE: Store the unopened bottles in the refrigerator. Once a bottle is opened for use, it may be stored at room temperature (up to 77 degrees Fahrenheit or 25 degrees Centigrade) for 6 weeks, unless otherwise instructed by your	F 431	Steps taken in regards to those residents found to have been affected: Expired eye drops were disposed of on 4/6/16. Steps taken in regard to those residents having the potential to be affected: On 4/6/2016, Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator conducted an inspection of all medication carts and medication rooms to ensure that all discarded medications were discarded	

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F 431	Continued From page 33 pharmacist. Discard any opened, unused bottles after this time period." A facility policy titled "Dating protocol instructions" updated January 2015 stated latanoprost ophthalmic eye drops should be discarded after 42 days. On 4/6/16 at 3:00PM, an observation was conducted of the 300 hall med cart. There was one vial of Latanaprost solution 0.005% with an opened date of 2/5/16. On 4/6/16 at 3:00PM, Nurse #4 stated the pharmacy guidelines of discarding after 42 days should have been followed and the medication should have been discarded.	F 431	and that all medications were properly labeled per facility policy. All medications were labeled correctly and no expired medications were found. Measures put into place to ensure deficient practice does not recur: - Director of Nursing, Assistant Director of Nursing and Staff development Coordinator in-serviced licensed nurses, including weekend and prn, on 4/20, 4/25 and 4/26 regarding labeling medication and discarding expired medication - Nurses will complete medication cart checks every shift using the Medication Cart Audit form. This will be completed every shift daily, indefinitely. How facility plans to monitor effectiveness of corrective action: - Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nursing Supervisor will conduct weekly audits of medication carts and medication rooms indefinitely. - Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will bring all audits to the Quality Assurance Committee for review. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	
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	F 441		4/26/16

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F 441	Continued From page 34 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 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, medical record review and staff interviews, the facility failed to place a contact precautions sign on the door for one of	F 441	Steps taken in regards to those residents found to have been affected: Contact Precaution sign was placed the	

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F 441	Continued From page 35 two residents on isolation precautions (Resident #75). The findings included: CDC (Center for Disease Control) guidelines recommend contact precautions when the facility (based on national or local regulations) deems MRSA (methicillin-resistant staphylococcus aureus) to be of special clinical and epidemiologic significance. Resident #75 was admitted 1/12/16 and last readmitted to the facility 2/9/16. Cumulative diagnoses included, in part: urinary retention, stage 3 kidney failure and methicillin-resistant-staphylococcus aureus (MRSA). The admission/5 day Minimum Data Set (MDS) dated 1/19/16 indicated Resident #75 was cognitively intact, She required extensive assistance with toileting. Resident #75 had an indwelling urinary catheter. No urinary infection was noted during the assessment period. A urinalysis report dated 3/28/16 indicated Resident #75 had a white blood cell count greater than 100 (an indication of a urinary tract infection). The urine culture report dated 3/31/16 indicated the infection was methicillin-resistant staphylococcus aureus. A care plan for Resident #75 dated 1/27/16 stated Resident #75 had a urinary device-urinary catheter. On 3/31/16, MRSA and urinary tract infection was added to the care plan. Interventions included standard precautions. During the initial tour of the facility conducted on 4/4/16 at 11:05AM, a PPE (personal protective	F 441	room door of Resident #75 on 4/5/16. Steps taken in regard to those residents having the potential to be affected: Administrator completed an audit on 4/6 to determine if proper signage was in place for all residents who were on contact precautions. All precaution signage was in place. Measures put into place to ensure deficient practice does not recur: - Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator in-serviced nurses and CNAs, including weekend and prn, on 4/20, 4/25 and 4/26 regarding posting proper signage on resident doors who are on contact precautions. Nurses were instructed on where contact precaution items are stored and how they should be posted on the doors. Contact precaution supplies are stored either in the supply room or the nurses stations. Signage will be placed either on the door of the resident□s room or in the isolation caddie. Hooks and contact precaution signs will be located at each nurses station. How facility plans to monitor effectiveness of corrective action: - A daily audit will be completed by Administrator, D.O.N. or department head to ensure that proper signage is posted on all the doors of rooms with residents who are on contact precautions. Auditing during the weekend will be conducted by the Weekend Manager or Nursing Supervisor. Audits will be completed daily for two weeks, then weekly for two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 36 equipment) cart was noted outside of Resident #75 ' s room. There was no contact precaution sign noted on the door. On 4/4/16 at 12:00PM, an interview was conducted with nurse #1 who stated Resident #75 was not on isolation. Nurse #1 stated Resident 75 had a urinalysis positive for MRSA and had a urinary catheter. He stated the PPE equipment was worn during catheter care. An observation on 4/5/16 at 4:00PM revealed there was no contact isolation sign on door. On 4/5/16 at 4:05PM, an interview was conducted with the infection control nurse. She stated there was a contact isolation sign on the door now for Resident #75. She stated Resident #75 had MRSA in her urine, had an indwelling urinary catheter and contact precautions should be observed when doing catheter care and emptying the urinary drainage bag. She said she had just placed the sign on the door and the sign should have been put up when the nursing staff received the culture that it was MRSA and the PPE equipment was placed at the door of the room as MRSA required contact precautions to be observed. A facility policy for contact isolation was requested but not received. On 4/5/16 at 4:05PM, the Director of Nursing stated she expected nursing staff to put up the contact isolation signs when they put the PPE equipment at the door.	F 441	months. Administrator and D.O.N. will also monitor this during morning rounds. - Audits and PoC will be taken to the Quality Assurance Committee by the Administrator or Director of Nursing. Any area of continued concern will be brought back to the QA committee by the administrator for further action plan.	