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	345283	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain the indwelling urinary catheter bag below the level of the bladder for 1 of 2 sampled residents who were observed transferred with a catheter in place (Resident #62). The findings included: Resident # 62 was readmitted to the facility on 10/14/15. Her diagnoses included chronic kidney disease and urine retention requiring the use of an indwelling urinary catheter. The annual Minimum Data Set (MDS) dated 9/30/16 coded her with requiring extensive assistance for transfers and having an indwelling urinary catheter. On 11/15/16 at 3:24 PM Resident #62 was observed being transferred from her wheelchair into bed via a total mechanical lift by Nurse Aides (NA) #2 and #3. Resident #62 was already	F 315	Those affected: The catheter bag was placed below the level of the bladder. Nursing assistant number 2 and number 3 were educated that the catheter must be below the bladder at all times. Those potentially affected: Inservices were provided to nursing staff regarding the catheter being below the bladder at all times to include when they are being transferred. Systemic changes: During transfers one nursing assistant will be responsible to manage the catheter below the level of the bladder while the other nursing assistant completes the transfer. Nursing staff was inserviced to this system. Monitoring and QA: Observation of residents who are a total mechanical lift will be observed for correct placement of the catheter below the level of the bladder	12/14/16

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

Electronically Signed | 12/02/2016

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F 315	Continued From page 1 sitting on a lift pad and staff placed her catheter bag on her lap. Once the pad was connected to the lift at 6 different points, NA #3 proceeded to hang the catheter bag in front of the resident's face on the bar which held the lift pad. As Resident #62 was lifted up via the mechanical lift, the catheter bag raised above the resident's head and chest area. Once the resident was moved over the bed and then lowered the catheter bag was placed on the bed and eventually moved to the side of the bed where it was lower than the bladder. On 11/15/16 at 3:37 PM NA #3 was interviewed regarding the position of the catheter bag. She stated that she was taught that the catheter bag needed to be maintained below the bladder but did not think it was necessary for the short time it took to transfer her. She stated she did not know what to do with the catheter bag when she used the total lift. Interview with the Director of Nursing on 11/16/16 at 1:57 PM revealed she expected the catheter bag to be maintained below the level of the bladder even during the transfer. She further stated further education was needed.	F 315	during transfers. Audits will be conducted weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters. Results of transfer audits will be reviewed in QA meetings.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/14/16

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to put effective interventions to reduce the risk of falls for 1 of 5 residents with repeated falls (Resident #91). The findings included: Resident #91 was admitted to the facility on 04/14/14. His diagnoses included Parkinson's Disease, dementia, transient cerebral ischemic attack, anxiety disorder, hypertension and dysphagia. He was admitted to hospice on 02/05/15. The Care Area Assessment (CAA) for falls dated 02/24/16 stated Resident #91 was at risk for falls due to his decreased safety awareness, impulsiveness, generalized weakness, shuffling gait, Parkinson's Disease and history of falls. Review of his fall care plan, which was initiated on 04/15/14 and remained in place until he died on 10/31/16, revealed Resident #91 had the goal to have no falls with injury for 90 days. Interventions included: *staff to remind resident to use call light when attempting to ambulate or transfer; *maintain a clutter free environment in his room; *when in bed, place all his necessary personal items in reach; *monitor for and assist with toileting needs; *non skid socks when his shoes were not on; *keep bed at appropriate height for safe transfers; *keep the call light with in his reach at all times; *check resident frequently when in bed; and *keep urinal close to bed so he could easily reach	F 323	Those affected: Patient has discharged from the facility. Those potentially affected: Residents with more than one fall,(more than one fall in 180 days), have been reviewed to assure care plan reflects interventions with falls. Systemic changes: Residents with one or more falls, as described above, will be reviewed in morning clinical meeting. Interventions will be discussed and implemented as determined by the Interdisciplinary team. Patient with falls will be reviewed during weekly Customer at Risk meetings to discuss trending patterns of the falls. Any changes to the care plans will be made at the customer at risk meetings. Monitoring and QA: Residents with falls, (more than one in 180 days), will be audited to assure interventions were implemented and careplanned as indicated. Audits will be performed weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters. Results of audits will be reviewed in QA meetings.	

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it.

Review of the Kardex which nurse aides used for cues toward resident care needs included side rails were used as an enabler; non skid socks were used when shoes were not on; and extensive assistance of one person was used for bathing, grooming and dressing.

The quarterly Minimum Data Set (MDS) dated 08/12/16 coded him with a decline in cognition, now having severely impaired cognitive skills. He was also coded as requiring extensive assistance with bed mobility, transfers and walking in his room. He was coded as not walking in the hall. He was coded as not being able to stabilize himself without human assistance during transitions from seated to standing, from moving on and off the toilet, and during surface to surface transitions. He had 2 or more falls with no injury and one fall with a nonmajor injury since the last assessment. No changes were made to the care plan after this quarterly assessment.

Review of the Event Summary Reports and nursing notes, revealed Resident #91 had additional unwitnessed falls since the 08/12/16 assessment. The Assistant Director of Nursing (ADON) stated during interview that when there was a fall, staff on duty obtained witness statements and note the fall in the computer so all nurses were aware of the fall. The next morning the hall nurses, administrator, Director of Nursing (DON), social worker and other disciplines involved discuss the fall and reason the all occurred. Then they attempt to put a plan in place. If they could not determine a reason then the facility tries low beds, floor mats, keeping the resdient close to the nursing station and

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therapy interventions at times. The DON stated on 11/15/16 at 2:48 PM each fall was reviewed in the morning meetings and then unit managers followed through with implementing new interventions. The unit manager for the unit where Resident #91 resided was the Assistant Director of Nursing (ADON).

*On 09/30/16 at 5:45 AM he was found sitting on his bottom on the left side of the bed. The report did not indicate what he was doing at the time of the fall. The DON stated during interview on 11/16/16 beginning at 3:13 PM she did not know what he was doing or when was the previous time he was checked. She said there should have been a mat in place. No changes in interventions were made and the interventions were to continue with a low bed, mat on the floor and call bell in reach. .

*On 09/30/16 at 7:30 PM he was found again sitting at the bedside on the floor. Again there was no indication of what he was doing prior to this finding. DON and ADON stated during interview on 11/16/16 beginning at 3:13 PM that at this point he was not getting up as much and not using the urinal on his own as much. They stated that they though he was exiting the bed from the door side(middle of room). The DON described him as always having been a person who puttered around his room. She further stated that the facility did not use alarms and they look at the quality of life for the residents. She stated he was going to fall and they were going to try to prevent injuries. No additional interventions were implemented.

*On 10/24/16 at 3:45 AM Resident #91 was found on the floor on his left side on the left side of the

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bed (toward door). The bed was in the low position and the nonskid socks were in place. There was no explanation as to what he was doing prior to this fall. The DON stated during interview on 11/16/16 beginning at 3:13 PM that the following morning changes were made and Ativan (antianxiety medication) was added as needed and increased to his Roxanol (pain medication) because he was restless most of the time.

*On 10/25/16 at 6:00 AM he was found on the floor on the left side (door side) off the floor mat. The report noted he had been observed throughout the night with his eyes closed. There was no root cause analysis to determine the cause of the fall. The DON and ADON stated during interview on 11/16/16 beginning at 3:13 PM that he was impulsive and wanted to ambulate. When asked about any expectations related to how staff were to supervise Resident #91, they stated the staff were in the room frequently and his room was close to the nursing station. They were unable to explain any root cause analysis of the fall or what specifically was done to prevent falls or injures.

Despite Resident #91 falling repeatedly, there was no indication that staff attempted to discover any trending of the circumstances around the falls and or make changes to the care plan specific to the type of supervision or assistance he needed to prevent falls.

Interviews with staff who worked with him revealed the following:

On 11/13/16 at 3:59 PM Nurse Aide (NA) #4, who worked 7:00 AM to 7:00 PM on weekends and

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one day during the week, stated that residents who were at risk for falls often accompanied the nurses during medication pass for increased supervision. She was unable to ever recall this resident falling during her shifts and recalled towards the end of Resident #91's stay the facility added foot rests to the wheelchair as he would not keep his feet elevated during transport. She stated she recalled him having a low bed and mat on the floor between the two beds. She recalled hearing that he fell on the other side of the bed, by the AC unit but not during her shifts. She was not sure if a mat had been placed between the bed and the AC unit.

On 11/13/16 at 4:05 PM NA #5 who worked 7:00 AM to 11:00 PM was interviewed. She stated she recalled the resident falling once because he would not lean back in the wheelchair. She stated he often transferred himself despite being unsafe and fell even with the use of a low bed and mats. She described him as being strong willed and in his younger days was very active physically. She stated he began to decline a few months before his death.

Nurse #2 was interviewed on 11/13/16 at 6:01 PM. She described Resident #91 as squirmy and a fall risk. She stated she checked on him hourly during the one or two times she had him and when he was up in a wheelchair staff kept him close to the nursing station. She recalled he had always a low bed and mats on the floor.

Nurse #3 was interviewed on 11/16/16 at 8:11 AM. She stated she worked generally Tuesdays through Fridays first shift. She described Resident #91 as being very independent. His bed was kept in the low position, there was a mat

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F 323	Continued From page 7 between the two beds and he wore nonskid socks. She stated the mat was beveled because he walked. She continued stating that he had some communication issues and to some extent he seemed confused. He was able to point and shake his head as forms of communication. She stated that they tried to keep him at the nursing station and keep his wheelchair close to him when he was in bed. She further stated that they reminded him to use the call light but was not sure if he remembered those instructions. The hospice nurse was interviewed on 11/16/16 at 9:18 AM. She stated Resident #91's mind was intact for the most part but his body did not cooperate. She stated that if he was restless staff would change positions such as get him up from bed or put him in bed. She further stated sometimes he probably could remember his abilities but wanted to do things on his own and other times he probably did not remember to call for help. NA #6, who normally worked second shift with Resident #91 stated during interview on 11/16/16 at 9:27 AM that in the beginning, Resident #91 used his urinal but he slowly declined in his abilities. To try to keep him from falling, she stated he became in need of two persons to assist and staff tried to go to his room more often. She stated they kept the door open so staff could look inside and see him as they passed his room. They also kept his bed in the lowest position and a mat between the two beds.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive	F 328		12/14/16

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F 328	Continued From page 8 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to obtain a physician order for oxygen for 1 of 2 residents reviewed for oxygen (Resident #123). The findings included: Resident #123 was admitted to the facility on 07/25/16 with diagnoses of heart failure, diabetes and end stage renal disease. Review of the physician orders from 11/01/16 through 11/15/16 revealed there was no order for oxygen for Resident #123. An observation made on 11/15/16 at 11:30 AM revealed Resident #123 had oxygen via nasal cannula at 2 liters. During an interview conducted on 11/16/16 at 9:55 AM the Director of Nursing (DON) stated all residents that received oxygen required a physician order. She reviewed Resident #123's physician orders for November 2016 and agreed there was no order for oxygen. The DON stated it was her expectation for Resident #123 to have a physician's order for oxygen.	F 328	Those affected: Resident number 123 had orders written for oxygen use. Those potentially affected: Residents with oxygen use was audited to assure patients had physician orders. Systemic changes: When residents are admitted the nurse will review the discharge summary to assure orders are continued from the hospital. Patients with oxygen orders in the discharge summary will have a call placed to the Family Nurse Practitioner or the physician to obtain orders. Staff will be inserviced to review the discharge summary and reconcile against admission orders. Monitoring and QA: Audits will be completed for residents on oxygen weekly times 2 weeks, monthly times 2 months and quarterly times 2 months. Results of audit will be reviewed in Quality Assurance meetings.	

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F 356	Continued From page 9	F 356		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post the nurse staffing information on 1 of 4 days of survey and during the previous	F 356	Those Affected: The staffing sheet for Sunday, November 13th, was posted when brought to staff's attention.	12/14/16

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F 356	Continued From page 10 weekend. The findings included: On 11/13/16 at 5:14 PM the nurse staffing hours posting was observed. The postings were across fro the 100/300 hall nursing station. At this location was an assignment sheet with staff names and their assigned units which was dated Friday 11/11/16 and the nursing staff hours for each shift which was dated Thursday 11/10/16. These postings were changed to the correct date when observed on 11/14/16 at 8:30 AM. An interveiw with Nurse Aide (NA) #1 was conducted on 11/16/16 at 8:32 AM. NA #1 stated on Wednesdays she was responsible for changing the staffing hours. NA #1 stated the staffing coordinator posted the information on the other weekdays. NA #1 stated that the staffing coordinator gathered the information for the weekend postings on Friday and then the weekend supervisor was responsible for posting the staffing information on the weekends. During an interview with the Director of Nursing (DON) on 11/16/16 at 4:26 PM, she stated that the staff posting information was to be posted by the weekend supervisor and this past weekend Nurse #1 was the weekend supervisor. The DON continued to say that Nurse #1 was new to the supervisor role and needed more education. A phone interview was conducted with Nurse #1 on 11/16/16 at 4:30 PM. She stated the weekend postings were generally kept at the nursing station and she did not always post it because the nurse aides usually got their assignments from the nursing station. She was unaware the	F 356	Those potentially affected: The staffing sheets, for Sunday, were posted by staff when brought to the staff's attention. Systemic changes: Facility will continue to have the nursing supervisor post staffing on weekends but the change will be that the weekend manager on duty will audit these during the weekends to assure the staffing sheets are posted. Nursing staff and leadership team were inserviced on this change. Monitoring and QA: The daily staffing sheets will be audited daily times 1 week, weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters. Results will be reviewed in the QA meetings.	

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F 356	Continued From page 11 regulation required the nurse staffing hours be posted. Nurse #1 further stated she was aware they were posted during the week.	F 356		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to, remove outdated items from a nourishment refrigerator and label opened cartons of milk in 1 of 2 nourishment refrigerators. The findings included: On 11/13/16 at 3:51 PM observations were made of the dayroom 1 refrigerator with the Food Service Director (FSD). Observations inside the refrigerator revealed: - Two cartons of milk opened and undated - A container of thickened liquids dated 11/7 - A box of Kentucky Fried Chicken dated 11/2 - A fruit basket dated 11/7	F 371	Those affected: The open undated and outdated foods were thrown away by the Food Service Director the day of the survey when she was notified of the situation. Those potentially affected: Refrigerators in facility was checked to assure no undated opened or outdated items were in the refrigerators. Systemic changes: The refrigerators will be checked daily for opened undated or outdated items by the weekend manager on weekends and by the Food Service Director during the weekdays. A form was created where documentation of refrigerators without open undated or outdated foods can be audited.	12/14/16

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F 371	Continued From page 12 The FSD was interviewed about the items and stated leftover food was good for 3 days. She stated staff were expected to date any opened item including milk cartons for use. The FSD removed the milk cartons. The FSD stated thickened liquids was good for 3 days once opened. The FSD explained that dietary staff, nursing staff and housekeeping staff were expected to check items stored in the refrigerator and remove anything dated past three days. The FSD stated she had checked the refrigerator a few prior and offered no explanation why the items were allowed to stay stored for use past 3 days.	F 371	Inservices were provided on this system change. Monitoring and QA: Audits will be conducted daily times 1 week, weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters. Results of audits will be reviewed in QA meetings.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520		12/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 11/16/2016

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F 520	Continued From page 13 requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in October 2015. This was for one recited deficiency originally cited in October 2015 on an annual recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of kitchen sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: This tag is cross referred to: F 371: Based on observations and staff interviews the facility failed to, remove outdated items from a nourishment refrigerator and label opened cartons of milk in 1 of 2 nourishment refrigerators. In October 2015 the facility was cited for F 371 for failing to maintain kitchen equipment in a clean and sanitary manner to prevent food borne illness by failing to clean the walk in freezer floor, a steam table shelf and a fan in the dish room.	F 520	Those affected: Facility implemented a check and balance system to documentation refrigerator does not having undated open or outdated items. Those potentially affected: Facility implemented a new process of documentation daily of refrigerator without undated open or outdated items. Systemic changes: Daily documentation of refrigerator being in compliance with no open undated or outdated items was implemented. Staff inserviced on new system and that no food can be stored in the refrigerators unless they are dated when open and no outdated items are to be in the refrigerator. Staff were educated that food items once opened can only stay in the refrigerator 3 days. After three days the items are to be thrown away. Monitoring and QA: Documentation of checks of the refrigerator will be conducted daily indicating no open undated or outdated items were in refrigerator. Audits will be performed on the documentation daily times 2 weeks, weekly times 2 weeks, monthly times 2 months and quarterly times 2 quarters.	

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F 520	Continued From page 14 On 11/16/16 at 4:25 PM the Administrator was interviewed and stated the facility had a Quality Improvement Committee that met monthly to discuss, identify and review areas for improvement. The Administrator reported that Committee had an ongoing performance improvement concern related to kitchen sanitation because of the facility's history with a citation. The Administrator stated the Food Service Director made reports monthly and no concerns related to kitchen sanitation had been identified and/or reported.	F 520		