STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345091	A. BUILDING ______ B. WING ______	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD PLACE AT THE VILLAGE AT BROOKWOOD	1820 BROOKWOOD AVENUE BURLINGTON, NC 27215

(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 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive assessment (Minimum Data Set and Care Area Assessment) within 14 days after admission to the facility for 1 of 16 sampled residents (Resident # 160) reviewed for comprehensive assessments. The findings included: Resident #160 was admitted to the facility on 6/5/16 with diagnoses of ulcerative colitis, urinary tract infection, end stage renal disease, nephrotic syndrome with unspecified morphologic changes, anemia in chronic kidney disease, hypotension of hemodialysis, muscle weakness, and dependence on renal dialysis. A review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) 6/12/16 and Care Area Assessment (CAA) revealed that the CAA for Cognition was completed by Social	F 273	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident #160 had a comprehensive assessment completed on 7/6/16. An audit of all current residents will occur to verify the most current admission/readmission assessment was completed within 14 days. Any assessments that are currently open will be completed within 14 days from admission. MDS Coordinators will be educated on	1/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/23/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 273	Continued From page 1 Worker #2 on 7/6/16 at 09:25am, 31 days after admission and the CAA ' s for Activities of Daily Living and Falls were completed by MDS Nurse #1 on 7/5/16 at 4:14pm and 4:17pm, respectively, 32 days after admission. During an interview with the MDS Nurse #1 on 12/08/16 at 10:37am, it was confirmed that the "CAAs are due 14 days after admission and they are always late." The MDS Nurse #1 confirmed that the CAAs were initiated but not completed until the dates listed above. During an interview with the Director of Nursing (DON) on 12/08/2016 at 9:54am it was communicated the expectation was that the staff follow all policies and complete documentation on time. The DON further stated that it is her expectation that residents are correctly assessed and coded. An interview with the Administrator on 12/08/2016 at 2:32PM revealed that it was his expectation that the comprehensive MDS assessments would be completed as required and staff notify administration when assessments are not completed in a timely manner.	F 273	Resident Assessment Instrument guidelines regarding completion of admission/readmission assessments. MDS Coordinators will attend the North Carolina MDS 3.0 Training 2017 offered by the Division of Health Services Regulation, Nursing Home Licensure and Certification Section offered by Mary Maas, RN, MSN. During clinical meetings, the MDS Coordinator will bring a list of any assessment that has an Assessment Reference Date or a Completion Date of that day for review. Director of Nursing will be notified if an assessment is not completed timely. This will occur 5 x weekly x 4 months. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 276		1/5/17

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F 276	Continued From page 2 by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the previous quarterly MDS assessment for 1 of 16 residents (resident #152) reviewed. The findings included: A review of resident #152 admission MDS was dated 5/13/16. The assessment revealed the resident was admitted to the facility on 5/6/16 with diagnoses that included but not limited to: hypertension, malnutrition, and blindness. Review of the resident ' s MDS assessment dated 8/12/16 was marked as quarterly assessment and was signed as being completed on 8/29/16. During a review of the resident ' s most recent quarterly MDS assessment dated 11/12/16 revealed the assessment was in progress and not completed. Further review of the assessment revealed Section Z for signature of persons completing the assessment and Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted. During an interview with MDS Coordinator #1 on 12/07/2016 at 08:04 AM, the MDS Coordinator stated that she is aware that the quarterly assessment is incomplete for Resident # 152. The MDS Coordinator further stated that she is behind on her assessments. During an interview on 12/08/2016 at 9:54 AM with the facility ' s Director of nursing [DON], she stated that it was her expectation that all assessments be completed on time. During an interview with the Administrator on 12/08/2016 at 2:32PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required	F 276	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident #152 had a quarterly assessment completed on 12/09/16. An audit of all current residents will occur to verify the most current quarterly assessment was completed within 92 days. Any assessments that are currently open will be completed within 92 days from previous assessment. MDS Coordinators will be educated on Resident Assessment Instrument guidelines regarding completion of quarterly assessments. MDS Coordinators will attend the North Carolina MDS 3.0 Training 2017 offered by the Division of Health Services Regulation, Nursing Home Licensure and Certification Section offered by Mary Maas, RN, MSN. During Clinical Meeting, the MDS Coordinator will bring a list of any assessment that has an Assessment Reference Date or a Completion Date of that day for review. Director of Nursing will be notified if an assessment is not completed timely. This will occur 5 x weekly x 4 months. The results of these audits will be reviewed by the Director of Nursing	

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F 276	Continued From page 3 and staff notify administration when assessments are not completed in a timely manner.	F 276	Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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	F 278		1/5/17

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F 278	Continued From page 4 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for a resident that had palliative care and the nursing home staff providing care, and bowel appliances for 2 of 16 sampled residents (Resident # 63 and 152). The findings included: 1. Resident # 63 was admitted to the facility on 11/27/15 with diagnosis that included but not limited to Heart failure, Hypertension, Thyroid disorder, Non - Alzheimer's dementia, Anxiety disorder, Chronic obstructive Pulmonary Disease [COPD]. A review of the most recent Minimum Data Set (MDS) assessment dated 11/30/16 marked as a significant change assessment, revealed the assessment was coded as the resident ' s activity of daily living [ADL] as follows: bed mobility as activity occurred only once or twice with one person physical assistance for 7 of 7 days of the assessment period. The resident ' s transfers, dressing, toileting, personal hygiene, bathing and eating was coded as the activities did not occur at any time for 7 of the 7 days of the assessment period. The assessment also had marked that the resident did not have a life expectancy of less than 6 months.	F 278	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident #63 had a modification of the significant change MDS on 11/12/16to reflect accurate activity of daily living (ADL) care and a prognosis of 6 months. Resident #152 had a modification of the admission MDS on12/22/16 to reflect accurate ADL care and presence of a colostomy. An audit of all current residents most recent MDS assessment will occur to verify ADL accuracy. Any residents receiving palliative care, hospice services, or have bowel appliances will have their most recent MDS audited to verify accuracy of assessment. MDS Coordinators will be educated on Resident Assessment Instrument guidelines regarding accuracy of assessments related to ADL care, end of	

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Review of the initial hospice assessment dated 11/4/16 indicated that the resident had a prognosis of 6 months or less.

Review of a physician note dated 10/ 25/16, had documentation of palliative care consult related to declining health. Another Physician note dated 10/27/16 revealed hospice referral had been ordered.

Review of the resident ' s most recent updated care plan dated 10/31/16 revealed hospice care started on 11/1/16 with a goal to keep resident comfortable and interventions to provide basic comfort measures like oral care, hygiene, position changes, etc. to be provided by both hospice and facility nursing.

During a review of the hospice nursing assistant progress notes dated 11/16/16, revealed the resident was provided a bath and all care. Resident was checked throughout the day and toileted as needed. Meal intake was documented as breakfast 90% and lunch 100%.

Review of hospice nursing notes dated 12/2/16 revealed the resident was provided care in accordance to hospice care plan and the resident consumed 75% of breakfast.

During review of the facility nursing notes dated 11/27/16 the resident was provided a bath and was dressed with the assistance of one person. The Nursing home nursing staff note further indicated that the resident was fed by nursing home staff.

Review of the facility nursing notes from the

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life diagnosis/services, and bowel appliances. MDS Coordinators will attend the North Carolina MDS 3.0 Training 2017 offered by the Division of Health Services Regulation, Nursing Home Licensure and Certification Section offered by Mary Maas, RN, MSN.
MDS Coordinator will maintain an accurate listing of all residents with bowel appliances or end of life documentation including palliative care and hospice residents. This list will be updated 5 x weekly x 4 months during Clinical Meeting.
The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.

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F 278	Continued From page 6 weekend of dated 12/3/16 read in part: resident assisted with activities of daily living (ADL ' s) from the nursing home staff. Review of the facility ' s dietitian notes dated 11/11/16 revealed resident ' s diet was reviewed by the facility ' s dietitian to provide more variety, comfort care and honor family and resident wishes. Review of dietitian notes dated 11/27/16 revealed resident was currently on a regular diet and Gatorade was included on both the lunch and supper tray. An observation of resident #63 made on 12/06/2016 at 1:38 PM revealed Resident #63 sleeping in a geriatric chair in her room. Nursing home staff walked into resident ' s room to see if resident was comfortable. An observation was made on 12/07/2016 at 8:44 AM of Resident #63 being fed by hospice staff. Resident was sitting on a geriatric chair and watching television. An observation was made on 12/07/2016 at 2:35 PM of Resident #63 sleeping on her bed. An interview with the nurse #1 on 12/07/2016 at 7:32 AM, the nurse stated that the resident is provided care in the morning by hospice staff and facility ' s nursing assistants and nursing staff provide resident ' s care during the night and over the weekend During an interview with the nurse #7, on 12/07/16 at 8:41 AM, the nurse stated that the resident ' s activity of daily living were taken care during the day by the hospice nursing assistant Monday through Friday . The nurse further stated that the resident ' s needs are taken care by facility staff during nights shift and over the	F 278		

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F 278	Continued From page 7 weekend During an interview with the hospice Nursing Assistant #1 on 12/07/2016 at 8:45 AM, she stated that the resident is total care. She further stated that the resident ' s toileting needs are addressed as needed. She stated that resident was usually fed breakfast and lunch and the meal intake was documented in the chart. During an Interview with the MDS Nurse #1 on 12/07/2016 at 10:30 AM, the MDS coordinator stated that resident was on hospice care and a change of status MDS assessment was completed on 11/30/16. She further stated that resident ' s functional status like bathing, transfer, walking, toileting, dressing and personal hygiene are marked as activities never occurred on the MDS because care is provided by non-staff members. She stated that the resident ' s family, hospice care staff or nursing students take care of resident ' s activity of daily living. She further stated that according to the regulation, if the resident is not assisted by facility staff then it should be coded as " Activity did not occur - family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period " . Additionally, the MDS nurse stated that it was an oversight on her part for not marking the prognosis as terminally ill. During an interview with Director of Nursing [DON] on 12/07/2016 at 11:52 AM, the DON stated that the resident is provided care both by hospice and facility staff. She further stated that the resident does not receive 24 hours hospice service, but receives care by the facility staff in the night and over the weekend. She also stated that her expectations are for staff to follow the correct procedure when MDS assessments are	F 278		

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completed. The DON further stated that the functional status section on MDS was incorrect.

2. A review of resident #152 admission MDS was dated 5/13/16. The assessment revealed the resident was admitted to the facility on 5/6/16 with diagnoses that included but not limited to: hypertension, malnutrition, and blindness

Review of the Comprehensive MDS dated 5/13/16 coded as admission MDS revealed the facility coded resident for activities of daily living-eating as activity never occurred and nutrition approach was marked as parenteral IV feedings. Review of bladder and bowel appliance was not marked for ostomy.

Review of the nursing admission progress note dated 5/6/16 read in part: Patient is nothing by mouth (NPO) and Total Parenteral Nutrition (TPN) is administered through peripherally inserted central catheter (PICC) line for 16 hours. Patient fistula bag ordered to be changed every (q) 3 days.

Review of the quarterly MDS dated 8/12/16 revealed ostomy bag not marked for bladder and bowel appliance.

Review of quarterly assessment dated 11/12/16 revealed the facility coded the resident ' s activities of daily living as: transfers, walking, eating, and toileting did not occur any time during the 7 day look back period. The resident ' s bed mobility, dressing and personal hygiene was coded as having only occurred once or twice during 7 day look back period. Review of bladder and bowel appliance was marked for ostomy.

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F 278	Continued From page 9 During an interview with nurse #7 on 12/08/2016 at 9:15 AM, the nurse stated that the resident was admitted with a colostomy bag. The nurse further stated that the resident has had his nutrition provided via Total Parental Nutrition. During an interview with MDS nurse #1 on 12/08/2016 at 10:00 AM, she stated that she had not realized that there was a data error in the admission MDS. She further stated that she had made an error regarding how she coded the resident ' s activities of daily living. During an interview with Director of Nursing (DON) on 12/08/2016 at 9:54 AM, DON stated that she is well aware about the resident having an ostomy bag and that he was admitted on Parenteral Nutrition. The DON further stated that the resident should have been coded for having an ostomy bag. The DON stated that it is her expectation that residents are assessed and coded on the MDS correctly. During an interview with the facility administrator on 12/08/2016 at 2:32 PM, the administrator stated it is his expectation that the staff assess the residents appropriately and fix any the errors as soon as identified.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.	F 279		1/5/17

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483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

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F 279	Continued From page 11 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a care plan for implementing measures for 1 of 3 residents (Resident #232) who received an antianxiety medications and for behaviors of yelling out, for 1 of 3 residents (Resident #152) for ostomy care related to a bowel appliance (ostomy), and for 1 of 3 residents (Resident #206) for incontinent care. The findings included: 1. Resident #232 was admitted to the facility on 10/19/16 with a diagnosis that included traumatic ischemia of muscle, history of falling, Hypertensive heart disease with heart failure, sequelae of cerebral infraction and urinary tract infection (11/14/16) depression and anxiety. The MDS further indicated Resident #232 was severely cognitively impaired as evidenced by a Brief Interview for mental status (BIMS) of 3. Review of Resident #232 ' s care plan dated 10/20/16 revealed a problem of "I receive antidepressant medication and I am at risk for adverse effects". The goal stated Resident #232 would not experience adverse effects of	F 279	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident #232 had a care plan initiated for antianxiety medication on 12/22/16 and a care plan to reflect behaviors on 12/22/16. Resident #152 had a care plan initiated for a colostomy on 12/8/16. Resident #206 was discharged on 11/07/16 before care plan was initiated. An audit of all current residents will occur to verify there are care plans in place for any resident prescribed a psychotropic medications ,having behaviors, urinary incontinence, or bowel appliances. MDS Coordinators will be educated on Resident Assessment Instrument guidelines regarding accuracy of care	

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F 279	Continued From page 12 medication through next review. The approaches included administer medications per medical doctor (MD) order, assess/record effectiveness of drug treatment, monitor and report signs of sedation, hypotension, or anticholinergic symptoms, drug reduction as recommended by pharmacist and pharmacy consult review. Review of Resident #232 ' s care plan revealed no care plan for the administration of an antianxiety medication. The care plan further revealed no care plan in regards to Resident 3232's behaviors associated with the use of an antidepressant medication nor an antianxiety medication. Review of Resident #232 nursing note dated 11/12/16 revealed, Resident #232 had been yelling continuously for "help" today. Could not pinpoint what he wanted help with just that he needed help. Family member present and Resident #232 continued while she was sitting beside him. Review of initial psych note dated 11/14/16 revealed a chief complaint of stabilization of anxious behavior. Staff reported Resident #232 yelled out, had disorganized behavior and was perseverated over his bowels. Resident #232 complained of having loose stools, impaction, and bowel movements. The not continued that staff had checked him numerous times. Resident #232 thought he had bed sores on his backside. He has even described the bedsores to staff. The family stated these behaviors are new since Resident #232's CVA. Resident #232 seemed to be fixated on his bowels. Tends to be more anxious when family member not there. Recommend were to start Cymbalta 30 milligrams (mg) by mouth (po) qd (once a day) x 5 then increase to 60mg po qd thereafter for depression. The diagnosis codes indicated a diagnosis of Depression and anxiety.	F 279	plans related to psychotropic medications, behaviors, and bowel appliances. MDS Coordinators will attend the North Carolina MDS 3.0 Training 2017 offered by the Division of Health Services Regulation, Nursing Home Licensure and Certification Section offered by Mary Maas, RN, MSN. Care plans will be updated 5 x weekly x 4 months for any new psychotropic medication orders, behaviors, changes in continence, or newly placed bowel appliances. These areas will also be reviewed with care plan or risk meetings weekly x 4 months. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 279	Continued From page 13 Review of Resident #232's nursing note dated 11/17/16 revealed Resident #232 had been yelling all shift "help me" and he constantly stated he has a had a bowl movement. Resident #232 was checked and he was full of soft stool. Resident #232 was assisted out of bed by sit to stand lift to sit on the toilet in which he an extra-large bowl movement. Resident #232 continued to yell while in the bathroom to get off the toilet. The note continued with when Resident #232 was stood up and had another large bowel movement. Resident #232 yelled though lunch time "help me" refusing to keep his oxygen on. The NP was notified of the continued behaviors and new orders received to administer Ativan. Review of Resident #232's physician order dated 11/17/16 revealed lorazepam 0.5mg as needed (PRN) for anxiety and yelling out. Review of Resident #232's physician order dated 11/18/16 revealed Cymbalta 30mg 1 cap daily for depression. Review of Resident #232's physician order dated 11/24/16 revealed Cymbalta 60mg 1 cap for depression. Review of Resident 3232 ' s nursing note dated 11/27/16 revealed Resident #232 was yelling out saying he had diarrhea but when checked there was no stool noted. Review of psych follow up note dated 12/1/16 revealed Resident #232 was seen for a chief complaint of stabilization of anxious behaviors. The history of present illness indicated Resident #232 was previously seen for yelling out, disorganized thinking and perseverating over his bowels. Staff reported Resident #232 was doing much better. He was less anxious, perseverative. The note continued with Resident #232 had no tolerability issues with Cymbalta. Medications were identified as Cymbalta 60mg for depression	F 279		

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and Ativan 0.5mg every 4 hours PRN for anxiety.
Interview with NA#6 on 12/7/16 at 11:30am revealed Resident #232 exhibited behaviors such as yelling out when he had taken a BM or his bottom was burning. She indicated that checking the resident, cleaning him following a bowel movement, or putting cream on his bottom would minimize the behaviors.
Interview with Nurse #6 on 12/8/16 at 7: 44 am reveled resident #232 behaviors consisted of yelling out constantly. The resident normally yelled out in the instance he believed he had a bowl movement. Nurse #6 stated one day resident #232 was really anxious so we got an order for Ativan. The order for the Ativan PRN began on 11/17/16.
Interview with MDS Coordinator #1 on 12/8/16 at 11:05am indicated a care plan for anxiety should have been developed. She revealed she became aware of medication changes and behaviors in morning stand up meetings. MDS Coordinator #1 indicated she had missed including the use of an antianxiety medication to Resident #232 care plan. She indicated she care planned behaviors in the instance a resident had psychosis or combative behaviors. Resident #232 behaviors were far and few in-between.
Interview with the Director of Nursing (DON) on 12/8/16 at 2:50 pm revealed it was her expectation that the Resident care plans were developed and revised to reflect the resident ' s current plan of care. The DON further revealed the MDS coordinator received changes in medications and the care plan should reflect the changes in the resident's medications.

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F 279	Continued From page 15 2. A review of resident #152 admission MDS was dated 5/13/16. The assessment revealed the resident was admitted to the facility on 5/6/16 with diagnoses that included but not limited to: hypertension, malnutrition, and blindness. The facility coded resident as having parenteral IV feedings for nutrition approach. Review of bladder and bowel appliance was not marked for ostomy. Review of the nursing admission progress note dated 5/6/16 read in part: Patient is nothing by mouth (NPO) and Total Parenteral Nutrition (TPN) is administered through peripherally inserted central catheter (PICC) line for 16 hours. Patient fistula bag ordered to be changed every (q) 3 days Review of quarterly assessment dated 11/12/16 revealed the facility coded resident as having an ostomy bag. A review of the resident #152 active care plan was originally dated 5/19/16 and last revised on 11/30/16 revealed no documentation or care plan in place for resident ' s ostomy care. During an interview with nurse #7 on 12/08/16 at 9:15 AM, the nurse stated that the resident was admitted with a colostomy bag. During an interview with MDS coordinator on 12/08/16 at 10:00 AM. She stated that she had not realized that there was a data error in the admission MDS. She further stated that she was not aware that the resident was not care planned for ostomy care, but she indicated a care plan should have been developed for ostomy care. During an interview with Director of Nursing on	F 279		

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F 279	Continued From page 16 12/08/16 at 9:54 AM, DON stated that she is well aware about the resident having an ostomy bag. DON further stated that the resident should have been coded for ostomy bag. She also stated that the resident should have a care plan of ostomy care. The DON stated that it is her expectation that residents are assessed and care planned accurately. During an interview with the facility administrator on 12/08/16 at 2:32 PM, the administrator stated it is his expectation that the staff assess the residents appropriately so that the Care Area Assessments (CAA) are triggered and physicians have orders to address all the required CAA triggered care areas. 3. Resident #206 was admitted to the facility on 08/22/16 with the following diagnoses: Unspecified urinary incontinence, Urinary Tract Infection (UTI), unspecified E. Coli, fracture of right femur, history of falling and abnormalities of gait and mobility. frequent incontinence Review of admission Minimum Data Set (MDS) dated 08/29/16 revealed Resident #206 to have (defined as 7 or more episodes of urinary incontinence but at least one episode of continent voiding). Care Area Assessment (CAA) Summary triggered urinary incontinence and care plan decision. Review of Resident #206's medical record revealed no care plan or interventions for Resident #206 incontinence. Care plans (CP) dated 08/26/26, 09/13/16 and 09/28/16 did not indicate urinary incontinence as a problem on care plan. Last care plan conference noted on CP	F 279		

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F 279	Continued From page 17 was dated 09/15/16. Review of 90-Day MDS assessment dated 10/24/16 revealed significant change in Resident #206 status compared to the Admission MDS. MDS revealed that resident is always incontinent. Interview with MDS nurse #1 on 12/6/16 at 2:4pm revealed bladder and/or bowel episodes that were coded as frequent incontinence or always incontinent were always care planned. MDS Nurse #1 reported that a care plan should have been developed for Resident #206 urinary incontinence but was not. Interview with the DON on 12/06/16 at 2:34pm revealed it was her expectation that any concerns, problems or new situations should be addressed in the care plan in a maximum of 2 days. The DON stated that the interdisciplinary team meet Monday-Friday to discuss each resident's status. DON indicated that if a change in a resident is communicated, the CP is usually updated by MDS Nurse #1 or MDS Nurse #2 at that time. The DON revealed that if CP is not updated the information is communicated to the direct care staff during morning rounds each day.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	F 280		1/5/17

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request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

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F 280	Continued From page 19 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Record review and staff interview the facility failed to revise the plan of care for as resident that had a recent fall from the bed and had a changes in the use of an antibiotic related to a urinary tract infection for 1 of 3 sample residents (Resident #232). The findings included: Resident #232 was admitted to the facility on	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal	

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F 280	Continued From page 20 10/19/16 with a diagnosis that included traumatic ischemia of muscle, history of falling, muscle weakness, fibromyalgia, Hypertensive heart disease with heart failure, Cardiovascular accident (CVA), sequelae of cerebral infraction and urinary tract infection (UTI). The most recent Minimum Data Set (MDS) assessment dated 10/26/16 revealed Resident #232 required extensive assistance with bed mobility with the use of 2 staff and was totally dependent for transfers with the use of two staff. Resident #232 had impairments of the both upper and both lower extremities. The MDS further indicated Resident #232 was severely cognitively impaired as evidenced by a Brief Interview for mental status (BIMS) of 3. a) Review of Resident #232 care plan dated 10/26/2016 indicated a problem that Resident #232 was at risk for falling related to decreased mobility, self-care and medication use s/p Cardiovascular accident (CVA). The goal stated Resident #232 would remain free from injury through next review. The approaches included keep bed in the lowest position at all times. Review of nursing note dated 11/27/16 revealed Resident #232 was found on the floor next to his bed. No skin tears or injuries were noted. Resident #232 complained of pain in his left shoulder. The note continued that Resident #232 vitals were taken and Resident #232 was returned to his bed. Resident #232 was unable to state what happened. Day nurse and family were notified. Nursing would continue to monitor A Review of an electronic Incident report dated 11/27/16 revealed Resident #232 had an unwitnessed fall and was found on the floor beside his bed. The follow up section of the report was blank and not completed. Interview with Nurse #7 on 12/7/16 at 2:51pm	F 280	and state law. Resident #232 had their care plan updated with fall on 11/27/16 and intervention of checking for fecal incontinence and initiation of antibiotic on 11/08/16 and care plan was discontinued on 12/8/16 after patient was discharged on 12/7/16. All current residents that have had a fall since 11/1/16 will have their care plans reviewed for accuracy and implementation of interventions to prevent falls. Any current resident that has had an initiation of antibiotics since 11/1/16 will have their care plans reviewed for accuracy. MDS Coordinators will be educated on Resident Assessment Instrument guidelines regarding care plans related to updating and notification of interventions. MDS Coordinators will attend the North Carolina MDS 3.0 Training 2017 offered by the Division of Health Services Regulation, Nursing Home Licensure and Certification Section offered by Mary Maas, RN, MSN. Care plans will be updated 5 x weekly x 4 months for any new falls and intervention or newly ordered antibiotic therapy. These areas will also be reviewed with care plan or risk meetings weekly x 4 months. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality	

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F 280	Continued From page 21 revealed when falls occurred it was the responsibility of the shift nurse to complete an incident report. He indicated the facility would initiate a fall huddle. Nurse #7 indicated that prior to the fall huddle staff would put interventions into place such as frequent rounds or bathroom use. Interventions would be implemented based on a review of the fall. Nurse #7 could not recall any interventions put into place following Resident #232 ' s fall. Interview with MDS coordinator on 12/8/16 at 11:14am revealed she was made aware of falls daily from fall huddles. She indicated when a fall occurred the nurse would contact the on call nurse to relay the information regarding the fall. The huddle was to discuss why the fall may have happened and measures at attempt to prevent the fall from occurring in the future. She indicated she included new intervention after analyzing the situation surrounding the fall and the interventions put into place during the huddle. The MDS coordinator stated she was aware of Resident #232 had a fall from the bed. She indicated she could not recall if any interventions were put into place. She stated she had not update the care plan but should have following Resident #232 ' s fall. Interview with DON on 12/7/16 at 10:23 am revealed Resident #232 had one reported unwitnessed fall on 11/27/16. Resident #232 was found on the floor. She indicated the resident indicated he was sitting on the side of his bed and wanted to go somewhere. The resident complained of left shoulder pain. No injuries were noted. The DON stated that at the time of the incident Resident #232 ' s prevalon boots (heel protectors) were still in place. She further stated that was probably the reason he fell attempting to stand up with the prevalon boots	F 280	Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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on. The DON described Resident #232 as being confused and made poor decisions. The resident had to be reminded to use the call bell for assistance. The DON indicated the follow up report that would have had identified interventions put into place during fall huddle.
Interview with NA #6 on 12/7/16 at 11:30am revealed she was made aware of revisions to care plans by the responsible nurse. NA#6 stated she was unaware of any new interventions following Resident #232 fall on 11/27/16.
Interview with the DON on 12/7/16 at 3:49pm revealed the responsible nurse would fill out an incident report in the instance a resident had a fall. Following a fall the responsible nurse should be doing a fall huddle with staff about the details surrounding the fall. The nurse should call the " call out phone " in which a member of management is notified about the fall. The DON stated she could not locate a fall huddle sheet for Resident #232. The DON stated essentially the incident report is what happened at the time of the fall. The fall huddle includes measures put into place based on the details surrounding the fall and immediate interventions put into place following the fall. There was no follow up report competed. The DON stated that the resident ' s cognition and prevalon boots were the main issue for the fall. She further revealed she was responsible for completing the follow up section of the incident report and had not yet competed it. She further revealed falls were discussed at morning meeting and the expectation is that the care plan is updated with interventions to prevent falls.

b) Review of Resident #232 ' s care plan dated 10/26/16 revealed a problem of Resident #232 received antibiotics related to urinary tract

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(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 280	Continued From page 23 infection. The Goal stated resident #232 urinary tract infection would resolve without any complications by next review. The approaches included administer antibiotics per MD order, assess for UTI, document characteristics of color, encourage fluids monitor lab work and report abnormal values to NP or MD. Review of Urine Culture dated 10/23/16 indicated Resident #232 had bacteria enterococcus faecalis. Review of physician order dated 10/24/16 revealed ceftriaxone recon solution; 2 gram intramuscular. Special instructions stated give 2 G IM x 1 now. Reconstitute with lidocaine for UTI. Review of Physician order dated 10/24/16 revealed Cipro (ciprofloxacin HCL) tablet 250mg; amount 1 tablet oral. The special instructions stated UTI every 12 hours(x30). Review of nursing note dated 10/24/16 revealed positive UA results. Received new order for 1 x dose intramuscularly (IM) antibiotic and an order for Cipro 250mg x 30 doses. Interview with Nurse #6 on 12/8/16 at 7:44am revealed Resident #232 started Antibiotic on 10/24/16. Nurse #6 further indicated Resident #232 antibiotics ended on 11/8/16. Interview with MDS coordinator #1 on 12/8/16 at 11:05am revealed she became aware of medication changes through clinical morning meetings. If they finish the antibiotic she indicated she would go to the care pan and discontinue the care plan. Resident #232 antibiotic medication for his UTI had ended on 11/8/16. She further indicated she had not discontinued the care plan or UTI antibiotics use. She revealed it was an oversight. Interview with the DON on 12/8/2016 at 2:50pm revealed it was her expectation that care plans	F 280		

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F 280	Continued From page 24 are updated to reflect the resident ' s current plan of care. Residents #232 care plan for the use of antibiotics for a UTI should have been discontinued.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to follow interventions for fall precautions for a lowered bed for 1 of 3 sampled residents (Resident #232). The findings included: Resident #232 was admitted to the facility on 10/19/16 with a diagnosis that included traumatic ischemia of muscle, history of falling, muscle weakness, fibromyalgia, Hypertensive heart disease with heart failure, sequelae of cerebral infraction and urinary tract infection. The most recent Minimum Data Set (MDS) assessment dated 10/26/16 revealed Resident #232 required extensive assistance with bed mobility with the use of 2 staff and was totally dependent for transfers with the use of two staff. Resident #232 had impairments of the both upper and both lower extremities. The MDS further indicated Resident #232 was severely cognitively impaired as evidenced by a Brief Interview for mental status (BIMS) of 3.	F 282	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident #232 had bed lowered on 12/7/16. NA#6 was educated on fall interventions including keeping resident #232 bed in lowest position when care is not rendered. All nursing staff will be educated prior to their next shift worked related to Matrix Care (Nurses) and Matrix Point of Care (CNA□s) and reviewing Resident Profile to verify care plan interventions are in place on each resident.	1/5/17

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F 282	Continued From page 25 Review of Resident #232 care plan dated 10/26/2016 indicated a problem that Resident #232 was at risk for falling related to decreased mobility, self-care and medication use s/p CVA. The goal stated Resident #232 would remain free from injury through next review. The approaches included keep bed in the lowest position at all times. Review of Resident #232 fall risk assessment 10/19/16 revealed Resident #232 was high risk for falls with a score of 15. Review of nursing note dated 11/27/16 revealed Resident #232 was found on the floor next to his bed at 0525. Resident #232 complained of pain in his left shoulder and no other injuries were noted. The note continued that Resident #232 vitals were taken and Resident #232 was returned to his bed. Resident #232 was unable to state what happened. Day nurse and family notified. Nursing would continue to monitor. Observation on 12/17/16 at 8:38am revealed Resident #232 to be lying in bed in his room. Resident #232 bed was observed at standard height and not in the lowest position. Observation on 12/7/16 at 2:45 pm revealed Resident #232 to be lying in bed in his room. Resident #232 ' s bed was observed at standard height and not in the lowest position. Interview with Nurse #7 on 12/7/16 at 2:51pm revealed resident #232 ' s bed should be kept at the lowest position. Interview with nursing assistant (NA)#6 on 12/7/16 at 3:05 pm revealed Resident #232 ' s had had one fall during his stay. She indicated that she would be informed of interventions put into place following a fall by the responsible nurse. NA#6 could not recall any new interventions put into place following Resident #232 fall out of bed. Upon observation of	F 282	Director of Nursing, Nursing Supervisors, and Nursing Managers will complete an initial audit of all residents to verify fall interventions are in place. Director of Nursing Services, Nursing Supervisors, or Nursing Managers will complete audits of 10 residents weekly x 4 months to verify all fall interventions are in place. The results of these audits will be reviewed by the Director of Nursing Services or Executive Director and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Executive Director. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 282	Continued From page 26 Resident #232 lying in bed, NA#6 indicated Resident #232 ' s bed was not in the lowest position. She described Resident #232 ' s bed to be at standard height. NA#6 stated when care was completed NA ' s should be lowering the bed back to the lowest position prior to leaving the room. NA#6 described the bed being at the lowest position to mean as close to the floor as possible. Interview with the MDS coordinator on 12/8/16 at 11:14 am revealed interventions included in the care plan should be followed as written. In the instance an interventions are discontinued staff would be notified and the intervention would be removed from the care plan. The MDS coordinator continued that low bed meant that the bed should be kept as low to the ground as possible. Interview with the Director of Nursing (DON) on 12/8/16 at 2:50pm revealed it was her expectation that staff follow the interventions on the care plan to maintain a low bed for Resident #232.	F 282		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		1/5/17

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F 315	Continued From page 27	F 315		

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, physician interview and record review, the facility failed to have a diagnosis for an indwelling urinary catheter for 1 of 3 sampled residents (Resident # 239) with an indwelling urinary catheter.
Findings included:
Resident # 239 was admitted to the facility on 11/21/16 with diagnosis that included; Fracture of right acetabulum, other specified bacterial agents as the cause of diseases classified elsewhere-C. Diff (Clostridium Difficile), urinary tract infection (UTI), site not specified, resistance to vancomycin, gross hematuria, other abnormalities of gait and mobility-gait disorder

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

The resident #239 removed catheter independently and the NP ordered bladders scans on 12/06/16 to measure urine retention >250cc. Subsequent

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F 315	Continued From page 28 due to weakness, unspecified dementia without behavioral disturbance, and delirium due to known physiological condition. Review of the comprehensive admission Minimum Data Set (MDS) dated 11/28/16 resident was coded severely cognitively impaired. She was assessed to be totally dependent on staff for bathing and noted to need extensive assistance with toileting. MDS assessment revealed the resident had an indwelling catheter. Active diagnoses did not include neurogenic bladder or obstructive uropathy. Additional diagnoses did not include urinary retention. Review of nursing progress note dated 11/21/16, indicated Resident #239 admitting diagnoses as Altered Mental Status (AMS), UTI and Vancomycin-Resistant Enterococcus (VRE). Progress note included assessment of resident's abdomen as soft and non-distended. Further review of progress notes indicated contact precautions in place for VRE in urine. Admission assessment observation report dated 11/22/16 indicated Resident #239 urinary continence status as always continent. Appliances noted on admission assessment indicated an indwelling catheter. Review of the most recent care plan for Resident #239 dated 12/05/16 indicated the resident required an indwelling catheter which was present on admission with a short term goal that resident would not exhibit signs of UTI or urethral trauma through next review (target date 01/05/17). Interventions include-assess for continued need of catheter. Further review of nursing progress notes dated 12/06/16 revealed at 8:09 am Resident #239 indwelling catheter was intact with clear yellow urine draining with no indications of pain or discomfort noted. Progress note dated 12/06/16	F 315	readings were less than 250 ml on 12/07/and 12/08/16 and the resident was reported voiding without difficulty. A urology consult was ordered. On 12/20/2016, a 100% audit of residents indicated 3 residents with urinary catheters. Audit revealed appropriate assessment of the status of the resident and 2 of the 3 residents had orders that included justification for the catheters. The nurse practitioner was consulted and an appropriate diagnosis obtained. The nurse practitioner subsequently created a standard order set to be used that includes the order for the catheter , justification for the catheter, Foley size and balloon size and an order to fax any parameters for removal given by the discharging physician at discharge for a catheter present on admission. The standing order will also include removal attempts at 48 hours. All residents with indwelling catheters in place on admission will be assessed for justification for the indwelling catheter by medical record review completed by Director of Nursing, Nursing Supervisor, or Nursing Manager. If there is no justification, an order will be obtained from the Physician or Nurse Practitioner to remove the catheter. Education of all Nurses will occur on December 27th -29th, 2016, to include a review of the expectations related to Foley catheters and appropriate diagnosis for justification. Daily clinical meetings 5 times weekly x 4 months will include review/documentation of admission orders within 72 and tracking indwelling urinary	

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F 315	Continued From page 29 at 7:16pm revealed that Resident #239 pulled out her catheter in a.m. Nurse Practitioner (NP) ordered bladder scan q (every) 8h (hours); in and out (I&O) catheter if greater than (>) 250 mL (milliliters). May I&O x3 then leave catheter in I&O needed beyond 3; start date 12/06/16. An interview was conducted on 12/07/16 at 7:21am with CNA #4. CNA #4 reported that she had been caring for Resident #239 since admission on 11/21/16. CNA #4 reported that she had never noticed any abnormalities in resident ' s urine when providing care. CNA #4 reported that she provided catheter care for the resident every 2 hours. An interview was conducted on 12/07/16 at 7:26am with Nurse #16. Nurse reported that resident was admitted with indwelling catheter for infection in her urine. Nurse #16 reported that during her observations and assessment of resident, urine appearance was normal. Nurse #16 reported that she had not observed blood in resident's urine and that resident had not complained of any pain or discomfort. Interview on 12/07/16 at 9:30am with DON (Director of Nursing) revealed she was not familiar with resident, and stated "she must be fairly new." The DON reviewed electronic medical record and reported that she did not see "a concrete justification for an indwelling catheter." Telephone interview with NP (Nurse Practitioner) was conducted on 12/07/16 at 11:35am. When asked about the justification of catheter use, the NP stated "I can ' t tell you 100% why because I am not looking at her record but it was likely due to retention." The NP revealed that indwelling catheter was removed shortly after resident's admission to the facility but due to retention, the catheter was replaced. NP stated that bladder	F 315	catheters and the diagnosis for same. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	

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F 315	Continued From page 30 scans were ordered on 12/06/16 as a result of Resident #239 pulling indwelling catheter out. The NP indicated that if bladder scans were greater than (>) 250mL and bladder training was unsuccessful, Resident #239 would see the urologist for reinsertion of indwelling catheter. Review of Resident #239 bladder scan results revealed the following: 12/06/16-108mL, 12/07/16-47mL, and 12/07/16-206mL. An interview was conducted with DON on 12/07/16 at 2:25pm revealed the expectation for any resident admitted with an indwelling catheter is for the physician to assess the resident and to have a physician's order for the justification of use. Review of nursing progress notes dated 12/07/16 and 12/08/16 indicated that resident was voiding without difficulty with no requirement of I&O catheterization.	F 315		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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;	F 334		1/5/17

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(iii) The resident or the resident’s 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 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.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident’s 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 representative has the opportunity to refuse immunization; and

(iv) The resident’s medical record includes documentation that indicates, at a minimum, the following:

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F 334	Continued From page 32 (A) That the resident or resident's 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a policy and procedure that included the process of educating residents and/or families of the benefits and potential side effects of the influenza and pneumonia immunizations for 3 of 5 residents (Resident #193, Resident #63 and Resident #176) reviewed for immunizations. The findings included: The facility ' s policy dated 10/2015 and titled " Immunizations and Documentations " was reviewed. There was no documentation in the policy that reflected how the facility would provide education to residents and/or families (both upon admission and annually). 1a. A review of the facility ' s Preventive Health Care report dated 1/1/01-12/8/16 revealed that Resident #193 received the pneumonia vaccine on 8/10/16 but that education material was not provided. 1b. A review of the facility ' s Preventive Health Care report dated 1/1/01-12/8/16 revealed that Resident #63 received the influenza vaccine on 9/12/16 but that education material was not provided.	F 334	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident # 193, #63, and #176 were educated on influenza and pneumonia vaccinations on 12/23/16. A 100% audit of all current residents will occur on 12/28/16 to verify all residents and/or responsible parties were educated on influenza and pneumonia vaccinations. The policy has been revised and a letter created that will be mailed each year to the resident or the resident representative. The letter and the current CDC education for influenza and pneumococcal vaccines is mailed to the resident or the representative requesting consent for administration. The letter with consent is returned to the MDS nurse and is placed on the medical chart. Documentation of education is completed in the eMAR by the nurse administering	

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F 334	Continued From page 33 1c. A review of the facility ' s Preventive Health Care report dated 1/1/01-12/8/16 revealed that Resident #176 received the influenza vaccine on 9/27/16 but that education material was not provided. An interview with the Director of Nursing (DON) on 12/8/16 at 12:12pm confirmed that the policy did not include the education component. The DON reported that the education information is provided in the Admissions packet, along with an acknowledgement form that the resident or family signs, however, the policy did not reflect that information. During an interview with the DON on 12/8/16 at 2:10pm it was reported that " when the state was here last year this was an issue and we thought we had fixed it but we haven ' t. " She confirmed that annual education for vaccines is not addressed.	F 334	the vaccine. Upon admission, the Admission Director will obtain consent and present education regarding the influenza and pneumonia vaccinations. This information will be given to the Nurse Manager for completion. Education will be given to all Nurses to include administration and documentation of influenza and pneumonia vaccinations on 12/27/16, 12/28/16, 12/29/16. Audits will be conducted weekly of all new admissions x 4 months to verify education and administration of influenza and pneumonia vaccinations by Nursing managers. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 356		1/5/17

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F 356	Continued From page 34 (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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.	F 356		

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F 356	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the Facility failed to post the daily nurse staffing sheet for four of the four days during the recertification survey. Findings included: During the initial tour of the facility on 12/5/16 at 8:45am, the daily nurse staffing sheet was not observed to be posted anywhere in the facility. On 12/6/16 at 4:00pm, the daily nurse staffing sheet was not observed to be posted anywhere in the facility. On 12/7/16 at 3:15pm, the daily nurse staffing sheet was not observed to be posted anywhere in the facility. On 12/8/16 at 8:45 am, the daily nurse staffing sheet was not observed to be posted anywhere in the facility. During an interview with the DON on 12/8/16 at 11:20 am, the DON stated the daily nurse staffing sheet had not been posted for the previous two months. She further added the reason was due to a staff vacancy and that she knew this was an area of non-compliance. An interview was conducted with the Administrator on 12/8/16 at 11:52 am. The administrator stated he was not aware that the staff posting was not posted. The Administrator stated an employee resigned from the organization in mid-September and the need to reassign this responsibility was not picked up.	F 356	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. The facility failed to post nurse staffing information in a visible location for residents, visitors and staff to review. This was corrected on 12/14/2016 by placing an updated nurse staffing sheet in a visible location at the main entrance for residents, visitors and staff to review. The format is clear and readable and placed in a prominent location for residents and visitors. Public access to posted nursing staffing data is available to the public upon oral or written request for review as of 12/14/2016. The facility will maintain nurse staffing data for a minimum of 18 months. The Nursing Administration Scheduler or her designee will be responsible for the daily posting of the nurse staffing information at the beginning of each day. Posted data will be maintained for a minimum of 18 months. Information to be included in the posting will include: (i) Facility name (ii) Current date (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed personal directly	

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F 356	Continued From page 36	F 356	responsible for resident care per shift: (a) Registered Nurse (b) Licensed Practical Nurses or Licensed Vocational Nurse (c) Licensed Nursing aid (iv) Resident Census Audits will occur randomly 3 x weekly x 4 months to verify Nurse staffing is posted beginning 12/14/16 by the Director of Nursing Services. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		1/5/17

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F 371	Continued From page 37 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and facility staff interviews, the facility failed to store nutritional supplements under sanitary conditions. Findings included: An observation during the initial tour of the facility ' s kitchen on 12/05/2016 at 9:10AM revealed a black plastic crate with eight 6.0 ounce boxes and fifteen 8.0 ounce cans of nutritional supplements stored on the cooler floor, underneath a box of thawing meat in the facility ' s walk-in cooler. During an interview with the facility ' s chef on 12/05/2016 at 9:16 AM, he stated that the supplements were incorrectly stored in the cooler and should not have been stored on the floor. Further interview with the facility ' s chef on 12/05/2016 at 9:44 AM, he stated that the facility had no formal written policy and the staff is frequently informally trained on proper storage and labeling. During an interview with the facility ' s Dinning	F 371	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. On December 5, 2016, the nutritional supplements were removed from under thawing meet in the walk in cooler On December 5, 2016, a full kitchen inspection was completed by the Dining Director and Chef. Any concerns were corrected immediately. Education occurred with all managers and supervisors on December 9, 2016 to review storage, labeling, and dating procedures. All dietary staff were educated on policies and procedures related to storage, labeling, and dating foods on December 5, 2016 and December 6, 2016. Procedures are	

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F 371	Continued From page 38 service Director and facility ' s chef on 12/07/16 at 2:05 PM, the facility ' s chef stated that the facility has the policies on proper food storage and labeling. He further stated that the correct storage and labeling policies were printed and pasted on all refrigerators and in the dry storage area. The facility ' s dining service director stated that the facility has monthly meetings with staff and staff is educated on issues like food labeling and safe storage periodically.	F 371	posted throughout kitchen. Education will occur monthly x 4 at staff meetings and upon hire with any dietary staff. The Executive Chef and Sous Chef will monitor all labeling, dating, and food storage techniques on a daily basis x 4 months. If anything is found to be out of compliance, it will be corrected immediately and reviewed with the Dining Director weekly x 4 months. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		1/5/17

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conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 441	Continued From page 40 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to wash hands after cleaning the resident of stool during wound dressing for 1 out of 1 (Resident #17) observed for wound care. Findings included: The policy provided by the Director of Nursing titled Hand Hygiene, Policy Code: OP-IPD-1977-49 effective date January 1, 2015 stated, " #7. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings. #11. Decontaminate hands after removing gloves. " Same policy under the Other Aspects of Hand Hygiene Glove Use section stated, " #1. Decontaminate hands prior to putting on gloves. #5. Decontaminate hands after removing gloves " . Nurse #15 was observed performing dressing change for Resident #17 on 12/7/2016 at 5:19 AM. Nurse #15 washed hands in Resident #17 bathroom and donned clean gloves before	F 441	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain compliance with the federal and state regulations the facility has taken and will take the actions set forth in the plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Nurse #15 was educated on 12/8/16 to include proper handwashing techniques. All nursing staff will be reeducated on appropriate hand hygiene handling bodily	

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beginning to re-dress wound. Nurse #15 started by cleaning areas around wound with skin protective cloths. Nurse #15 then cleansed areas with saline. Nurse #15 changed gloves and proceeded to dry skin gently with gauze. Nurse #15 noted stool at rectum and removed stool from rectum, then removed gloves. Nurse #15 put on clean gloves and resumed re-dressing wound. Nurse #15 did not wash hands with soap and water after cleaning the resident of stool and before donning clean gloves and resuming wound care.

An interview was conducted with Nurse #15 on 12/07/2016 at 5:48 AM immediately after the observation regarding policy and procedure for hand hygiene. Nurse #15 stated, "Yes, use gel between glove uses; just did not have gel this morning. But yes, use gel between glove changes. "

An interview was conducted with RN Long Term Care Unit Supervisor/MDS Coordinator #1 on 12/07/2016 at 11:19 AM. She stated, " Wash hands and dry them; then put on new gloves and resume dressing change. "

On 12/07/2016 at 10:00 AM the Director of Nursing provided list of employee names completing Safety at Work and Compliance and Privacy mandatory educational courses and educational flyers utilized for education. Nurse #15 name not on educational list provided by Director of Nursing on 12/07/2016 at 10:00 AM as having completed Safety at Work education.

An interview was conducted with Director of Nursing on 12/07/2016 at 11:25 AM. She stated, " Wash hands and dry them; then put on new

fluids, waste, and donning and doffing gloves; compliance will be achieved by 1/5/17. Hand Hygiene audits will be conducted on all nursing staff monthly x 4 months by the Rehab Unit Supervisor for Edgewood Place and her designees and reported to the Director of Clinical Services and Cone Health Infection Prevention Department
The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will be revised as needed to ensure continued compliance.

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F 441	Continued From page 42 gloves and resume dressing change. When asked to clarify what meant by "wash hands" stated, " with stool, wash hands with soap and water". Director of Nursing stated this nurse was an agency nurse that joined them as an employee. She stated would contact Human Resources to request information on file for Nurse #15 regarding training. On 12/08/2016 at 12:12 PM, Director of Nursing stated Nurse #15 late completing mandatory requirements in the electronic system. Director of Nursing stated she had called Nurse #15 to come in today (12/8/2016) to complete training requirements. Student and Group Transcript Report for Nurse #15 provided by Director of Nursing on 12/8/2016 reviewed. Safety at Work training on Nurse #15 transcript dated 12/8/2016, noted as completed on 12/8/2016.	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		1/5/17

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F 520	Continued From page 43 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview the facility's Quality Assessment and Assurance Committee failed to develop a policy and procedure that included the process of educating residents and/or families on the benefits and potential side effects of the influenza and pneumonia immunizations that the committee put into place 10/29/15. This was for one recited deficiency that was originally cited 10/29/15 on a recertification survey and subsequently recited in December 2016 on the current follow up recertification survey. The deficiency was in the area of Influenza and Pneumococcal Immunizations (F334). The continued failure of	F 520	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Resident # 193, #63, and #176 were educated on influenza and pneumonia vaccinations on 12/23/16. A 100% audit of all current residents will occur on 12/28/16 to verify all residents	

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F 520	Continued From page 44 the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is crossed referenced to: F334: Based on record review and staff interviews, the facility failed to develop a policy and procedure that included the process of educating residents and/or families of the benefits and potential side effects of the influenza and pneumonia immunizations for 3 of 5 residents (Resident #193, Resident #63 and Resident #176) reviewed for immunizations. During the recertification survey of 10/29/15 the facility was cited at F334 due to failure to offer pneumococcal vaccine for 5 of 5 sampled residents. On the current follow up recertification survey the facility was recited for failure to develop a policy and procedure that included the process of educating residents and/or families of the benefits and potential side effects of the influenza and pneumonia immunizations for 3 of 5 residents Interview with the Director of Nursing (DON) on 12/08/16 at 3:31pm revealed the facility had no tracking system of providing education to residents and/or families on immunizations The DON indicated that on admission a discussion occurs with resident and/or families but no specific education provided.	F 520	and/or responsible parties were educated on influenza and pneumonia vaccinations. The policy has been revised and a letter created that will be mailed each year to the resident or the resident representative. The letter and the current CDC education for influenza and pneumococcal vaccines is mailed to the resident or the representative requesting consent for administration. The letter with consent is returned to the MDS nurse and is placed on the medical chart. Documentation of education is completed in the eMAR by the nurse administering the vaccine. Upon admission, the Admission Director will obtain consent and present education regarding the influenza and pneumonia vaccinations. This information will be given to the Nurse Manager for completion. Education will be given to all Nurses to include administration and documentation of influenza and pneumonia vaccinations on 12/27/16, 12/28/16, 12/29/16. Audits will be conducted weekly of all new admissions x 4 months to verify education and administration of influenza and pneumonia vaccinations by Nursing managers. The results of these audits will be reviewed by the Director of Nursing Services or Administrator and brought to the Quality Assessment Performance Improvement Committee meeting by the Director of Nursing Services or the Administrator. Any issues or trends identified will be addressed by the Quality Assessment Performance Improvement Committee as they arise and the plan will	

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F 520	Continued From page 45	F 520	be revised as needed to ensure continued compliance.	