STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	C 06/01/2017

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FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

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F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		7/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and a family interview the facility failed to notify the responsible party (RP) when routine pain medications were discontinued for 1 of 3 residents that were reviewed for notification of change (Resident #2). Findings Include: Resident #2 was admitted to the facility on 5/17/16 and discharged to another facility on 5/10/17. Her diagnoses included chronic pain syndrome and Alzheimer ' s disease. A quarterly minimum data set (MDS) for Resident #2 dated 4/13/17 revealed she had not received routine or as needed pain medication during the look back period. A staff assessment for pain was completed with no indications of pain identified. She was totally dependent for activities of daily living (ADL) and had severely impaired cognition. A care plan with an origination date of 1/23/17 for Resident #2 revealed she required pain management and monitoring. Interventions included administer pain medication per physician orders and notify physician if interventions are unsuccessful or if current complaint is a	F 157	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F157 Notification of Changes 1. Resident #2 was transferred to another facility on 5/10/17 therefore no notification could not be made. 2.Current resident's pain medication changes that have occurred over last 30 days to be reviewed for notification documentation. Notification was made based on the audit findings. 3.Current licensed nurses will be re-educated on the Change of Condition policy. Nurses will be instructed that notification must occur when pain	

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F 157	Continued From page 2 significant change from residents past experience of pain. A review of the physician orders for Resident #2 dated 3/9/17 revealed the order for Morphine 5 milligrams (mg) every 8 hours for pain was discontinued and a new order for Oxycodone 5mg every 4 hours as needed for pain was written. A review of the April 2017 medication administration record (MAR) revealed Resident #2 had not received any Oxycodone for pain. A review of the May 2017 MAR revealed Resident #2 received Oxycodone for pain on 5/3 - 1 dose, 5/4 - 2 doses, 5/5 - 5 doses, 5/6 - 6 doses, 5/7 -2 doses and 5/9 - 2 doses. An interview with the RP for Resident #2 on 5/31/17 at 10:54 am revealed that she had not been notified of the change in her mother ' s pain medication from routine to as needed until May 2017 when her mother had a fall. She stated the facility should have notified her back in March 2017 when the order was changed. An interview on 5/31/17 at 9:56 pm with Nurse #1 revealed she had been the nurse for Resident #2. She stated that Resident #2 could not really vocalize if she was in pain, but she did not display any non-verbal symptoms of pain. She stated after Resident #2 ' s injuries on 5/3/17 and 5/9/17 she received the pain medication more routinely because they wanted to make sure she wasn ' t having any pain from the injuries. An interview on 6/1/17 at 2:20 pm with Nurse #2 revealed that she was familiar with Resident #2.	F 157	medication changes are made. After the RP/family are notified the nurse must document that it was done and any responses from RP/family. The DON and or designee will re-educate Licensed Nurses. During Clinical start-up the order listing report will be reviewed for any pain medication changes and ensure that notification with documentation has occurred. 4. The Order Listing Report will be printed and reviewed x5/week for 4 weeks, x3/week for 4 weeks, and once/week for 4 weeks with focus on changes and/or new pain medications. The administrative nurses will check to be sure RP/family notification has occurred and documentation is completed. The DON will report to the QAPI committee. The QAPI committee will evaluate results and monitor to validate compliance.	

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F 157	Continued From page 3 She stated that Resident #2 wasn ' t displaying any signs/symptoms of pain and her pain medication was changed from routine to as needed. She stated that the RP was typically notified when a medication change was made and that the notification should have been documented in the nurse ' s notes. The nursing notes for Resident #2 were reviewed and there was no documentation that her RP was notified when her routine pain medication was changed to as needed. An interview on 6/1/17 at 3:35 pm with the Director of Nursing (DON) revealed that she could not see that the RP for Resident #2 had been notified when her routine pain medication was changed to as needed. She stated it was her expectation that the RP would be notified with this type of medication change.	F 157		
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 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	F 280		7/14/17

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F 280	Continued From page 4 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. (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.	F 280		

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F 280	Continued From page 5 (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 and update the care plan for Resident #3 for 1 of 6 care plans reviewed. Findings included: Resident #3 was readmitted to the facility on 4/9/17 with cumulative diagnoses which included dementia with Lewy Bodies. Review of the significant Minimum Data Set (MDS) assessment dated 7/19/16 was completed. The ----a (CAA) triggered Cognitive loss, Visual loss, Urinary Incontinence, Falls, Nutrition, Dehydration, Pressure Sores, and Psychotropic drug use and the facility indicated	F 280	F280 Right to Participate Planning Care-Revise Care Plan 1. Resident #3 careplan was updated 6/1/17. 2.Current residents have the potential to be affected by the alleged deficient practice. The Resident Management Director or designee will complete an audit of all current residents that had a comprehensive assessment during the last 30 days and be sure the residents plan of care accurately reflects residents status. The residents care plan will be	

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F 280	Continued From page 6 the status would be care planned. Review of the care plans revealed for: Cognition not been revised since 10/4/16 Falls had not been revised since 2/1/17 Pain had not been revised since 10/4/16 Pressure sores had not been revised since 12/3/16 Nutrition not been revised since 10/31/16 Psychotropic drug use had not been revised since 10/04/16 Visual loss not been revised since 10/4/16 Urinary Incontinence not been revised since 10/19/16 Interview on 6/01/17 at 1:40 PM with the MDS coordinator revealed she was recently hired at the facility and had to ensure all the MDS assessments were up to date. Further interview with the MDS who stated in the efforts of getting the MDS up to date, other staff knowledgeable of MDS and care plans came to the facility to assist and did not have an answer why the care plans for Resident #3 had not been updated. Interview on 6/1/17 at 2:06 PM with the administrator who stated the expectations were to have care plans updated at a minimal of quarterly and whenever necessary.	F 280	reviewed by the IDT to ensure the care plan reflects accurate status. New admissions care plan will be completed timely and thoroughly. 3. The District Director of Clinical Services and the Case mix Special will re-educate the Interdisciplinary Team and MDS Staff on accuracy related to care plan revisions and updates. The District Director of Clinical Services 4.The Resident Care Management Director will randomly review a minimum of 5 residents care plans weekly for 12 weeks to verify accurate revising of care plans. Opportunities will be corrected as identified as a result of theses audits. The results of the audit will be presented by the Resident Care Management Director monthly at the facility QAPI meeting. The committee will make changes or recommendations as indicated.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and	F 312	F312 ADL Care Provided For Dependent	6/29/17

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F 312	Continued From page 7 record reviews the facility failed to clean and trim the fingernails of Resident #3 who was dependent on staff for the completion of activities of daily living. This was evident in 1 of 3 residents reviewed who were dependent on staff for the completion of activities of daily living. Findings include: Resident #3 was readmitted to the facility on 4/9/17 with cumulative diagnoses which included dementia with Lewy Bodies. Review of the quarterly Minimum Data Set (MDS) assessment dated 5/1/17 coded the resident as requiring extensive assistance from staff for personal hygiene. Review of the written care plan revised 11/8/16 that indicated resident required extensive assistance with most activities of daily living and inform resident of the need to trim nails. If resident refused return at a later date to provide care. Observation on 5/31/17 at 11:31 AM revealed the resident had an accumulation of a brown colored substance under her nail beds on both hands and around the nail bed. Her nails extended about ½ inches above the nail bed and were jagged. Observation on 5/31/17 at 12:20 PM revealed the resident nail beds and hands remained in the same condition same. Observation on 5/31/16 at 1:15 PM revealed the nail beds remained with an accumulation of a brown colored substance under around the nail beds and under her nails.	F 312	Residents 1. Resident #3 received nail care on 5/31/17 at the end of first shift. 2. Current residents have the potential to be affected by this deficient practice. An audit performed on current residents was completed on 6/20/17. Current residents' fingernails were trimmed and cleaned if warranted. Residents that refuse nail care will be added to their Plan of Care. 3.Staff to be re-educated to provide nail care on shower days, with AM care, and as needed. Nails to be trimmed, filed, and cleaned. Consistent refusals of nail care will be reflected on the resident's Plan of Care. 4. Fingernails will be observed on 10 random residents 5x/weekfor 2 weeks. Then 5 random residents 3x/week for 4, and 2x/week for 6weeks by Unit Manager or designee. The DON will report to the QAPI committee and the QAPI committee will evaluate results and monitor to validate compliance.	

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F 312	Continued From page 8 Observation on 5/31/17 on 10:40 PM revealed the resident's nails and nail beds were clean and the nails trimmed. Interview on 5/31/17 at 11 PM with Nurse #3 stated she requested nail care to be done for Resident #3 (today on the day shift) but notice it was not done by the end of the shift so she completed trimming and cleaning the fingernails. Record review revealed no indication that Resident #3 refused nail care. Interview on 6/1/17 at 10:56 AM with Nursing Assistant (NA) #2 stated she was told that activity staff were cleaning nails. Then direction was provided by another nurse for me to reposition the resident so that whomever was cleaning, cutting nails and shaving residents would be able to easily access the resident. NA #2stated she knew Resident #3 required total care and had such information about the resident's need on the care card. Interview on 6/1/17 at 12:36 PM with the DON (Director of Nurses) stated her expectation was for staff to clean, cut or trim nails as needed.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 314		7/14/17

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F 314	Continued From page 9 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete treatments as ordered by the physician for pressure ulcers on the right heel and the left lateral foot for 1 of 3 residents reviewed for wound care (Resident #2). Findings Include: Resident #2 was admitted to the facility on 5/17/16 and discharged to another facility on 5/10/17. Her diagnoses included pressure ulcer of the right heel, Alzheimer ' s disease and heart disease. A care plan for Resident #2 dated 1/23/17 revealed she had an unstageable pressure ulcer to the right medial heel related to immobility. Interventions included administer treatments as ordered, assess and document wound measurements, status of wound perimeter, wound bed and healing progress. A quarterly minimum data set (MDS) for Resident #2 dated 4/13/17 revealed she had an unstageable pressure ulcer, was totally dependent for activities of daily living (ADL), had limited range of motion to her extremities and had severely impaired cognition.	F 314	F314 Pressure Sores 1. Resident #2 transferred to another facility on 5/10/17. 2.Any resident with a pressure ulcer is identified to be at risk. Nurse Practitioner to assess current residents with pressure ulcers and review orders. This will be completed by 6/29/17. Skin checks were completed on current residents. Treatment nurse, Charge Nurse, or weekend Nursing Supervisor to print Treatment Administration Record daily for the CNA II to sign off treatments until electronic privileges are granted. DON sent paperwork to the NCBON applying for the NA1+4 task approval so that CNAII can receive electronic privileges for charting. 3.CNA II provided education to ensure that she gets a new TAR printed daily prior to starting treatments and documents daily to reflect treatments completed. The treatment nurse and or designee will print the TAR for the CNA II. The licensed	

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F 314	Continued From page 10 A review of the physician orders for Resident #2 revealed an order dated 4/21/17 to cleanse her right heel with normal saline, apply skin prep, pack with collagen, and wrap with dressing every Monday, Wednesday and Friday. A review of the April treatment administration records (TAR), provided by the Director of Nursing (DON) revealed that there were 2 treatment records being maintained. A review of the skin assessment for Resident #2 dated 5/10/17 identified an unstageable right heel pressure ulcer with an onset date of 12/1/16. Measurements were documented as 1.0 centimeters (cm) length by 0.2 cm width by 0.1 cm depth. The pressure ulcer was 30% necrotic tissue and 70% granulation tissue with light serous drainage. A review of the skin assessment for Resident #2 dated 5/10/17 identified an unstageable left lateral foot pressure ulcer with an onset date of 4/10/17. Measurements were documented as 1.5 cm length by 1.3 cm width by 0 depth. The wound bed was brown and black, 100% necrotic tissue, with no drainage and no odor. An interview with the DON on 6/1/17 at 10:30 am revealed one TAR was being completed in the electronic medical record system (EMR) by the wound nurse and the second one was being completed in a handwritten form by Nursing Assistant #1 (NA) who also completed wound treatments. A review of the April 2017 TAR being maintained in the EMR revealed a treatment ordered 4/21/17	F 314	nurses will do the treatments on the weekend if the CNA II and treatment nurse are not working. Education was provided to the licensed nurses regarding this concept. 4.DON/designee to audit TAR for missing documentation x5/week for 4 weeks, x3/week for 4 weeks, then x2/week for 4 weeks.The DON will report to the QAPI committee the findings. The QAPI committee will evaluate results and monitor requirements to validate compliance.	

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F 314	Continued From page 11	F 314		

to cleanse right heel with normal saline, apply skin prep, pack with collagen, wrap with dressing every Monday, Wednesday and Friday. The treatment order was not signed off as being completed 4/21/17 through 4/28/17 when the order was discontinued. A review of the handwritten TAR did not contain the treatment order for the right heel dated 4/21/17.

A review of the April 2017 TAR being maintained in the EMR revealed a treatment ordered 4/23/17 to cleanse blister on outer aspect of left foot with normal saline and cover with Tegaderm dressing. Change every 3rd day and as needed. The treatment order was only initialed on 4/24/17 as being completed. The next scheduled treatment date of 4/27/17 was blank. The order was discontinued on 4/28/17. The April 2017 EMR TAR reflected a new order dated 4/28/17 to apply skin prep to the wound on the distal part of left lateral foot one time a day. The treatment order was not initialed as being completed on 4/29/17 and was discontinued 4/30/17. A review of the handwritten TAR did not contain the treatment order for the left foot dated 4/23/17 or the new treatment order dated 4/28/17.

A review of the April 2017 handwritten TAR revealed a treatment ordered 4/9/17 to apply Medi Honey wound / burn dressing gel to the right medial heel topically, wrap with kerlex every day shift on Monday, Wednesday and Friday. The treatment had been initialed as being completed on 4/24/17 however the order had been discontinued on 4/20/17. The Handwritten TAR did not reflect that the order had been discontinued on 4/20/17.

An interview on 6/1/17 at 11:10 am with NA #1

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FISHER PARK HEALTH AND REHABILITATION CENTER	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 314	Continued From page 12	F 314		

revealed that she was a Nursing Assistant 2 and completed wound treatments. She stated that she was familiar with Resident #2 and had completed wound treatments for her pressure ulcers. She stated that there were still 2 TAR ' s being maintained because she was not allowed to access the EMR. She stated that she was dependent on the nurse to provide her with any new treatment orders. The treatment orders noted above were reviewed with NA #1 and she stated that those orders had not been transferred to her copy of the TAR so she could not complete them. She stated nothing had changed since this area was cited on the last survey and that she could only do the treatments that were on her copy of the TAR.

An interview on 6/1/17 at 11:40 am with the wound nurse revealed he had started working at the facility in the middle of April 2017. He stated that he worked Monday through Friday as the wound nurse but he was sometimes pulled to pass medications. He stated that NA #1 worked Tuesday through Saturday. On the days they were both there he would typically work on the paperwork and NA #1 would complete the wound treatments. He stated she would complete the wound treatments on Saturdays and the nurse assigned to the resident would complete wound treatments on Sundays. He stated that NA #1 was not able to use the EMR and that if a treatment order was changed a new TAR should be printed off for NA #1 to use. He stated he was familiar with Resident #2 and that she had unstageable pressure ulcers to her right heel and her left foot. Both April 2017 TAR ' s were reviewed with the wound nurse and he acknowledged that wound treatments were missed. He stated that they needed to work on

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F 314	Continued From page 13 the process to ensure order changes were transferred to the handwritten TAR so treatments weren ' t missed or done incorrectly. An interview on 6/1/17 at 4:00 pm with the DON revealed that the wound nurse and NA #1 worked together on wound care but that the wound nurse was ultimately responsible. She stated all new wound treatment orders should be updated on the TAR including the handwritten copy that NA #1 used to complete treatments. After reviewing both April 2017 TARs she stated she was unable to determine if wound care was done as ordered for Resident #2. She stated that she was aware of the previous mistakes made with wound care and that the current system was not working and changes needed to be made.	F 314		
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 (g)(2) The quality assessment and assurance committee must :	F 520		6/29/17

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F 520	Continued From page 14 (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 staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 2/1/17 annual recertification survey. This was for recited deficiency in the area of pressure ulcers (F 314). This deficiency was cited again on a complaint investigation on 6/1/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA Program. Findings Included: This tag is cross referenced to: F 314 Pressure Ulcers. Based on record review and staff	F 520	F 520 Quality assessment and assurance 1. Resident # 2, as referred to in tag F314 in the 2567 had been discharged and no longer a resident at this facility at the time of the survey. No corrective actions could be taken for her orders. 2. Skin Checks were completed on all residents. Nurse Practitioner will assess residents identified with pressure ulcers and review treatment orders for accuracy. The remedy for tag F 314 will be followed and the results will be audited and reviewed in QAPI. 3. The Administrator, department managers and facility staff will be	

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F 520	Continued From page 15 interviews the facility failed to complete treatments as ordered by the physician for pressure ulcers to the right heel and left lateral foot for 1 of 3 residents reviewed for wound care (Resident #2). During the annual recertification survey of 2/1/17the facility was cited for F 314 for failing to complete dressing changes to a left foot pressure ulcer as ordered by the physician for 1 of 3 residents. An interview on 6/1/17 at 4:00 pm with the DON revealed that the wound nurse and NA #1 worked together on wound care but that the wound nurse was ultimately responsible. She stated all new wound treatment orders should be updated on the TAR including the handwritten copy that NA #1 used to complete treatments. After reviewing both April 2017 TARs she stated she was unable to determine if wound care was done as ordered for Resident #2. She stated that she was aware of the previous mistakes made with wound care and that the current system was not working and changes needed to be made.	F 520	in-serviced on the Quality Assurance and Performance Improvement Process 4. Administrator will hold monthly Quality Assurance and Performance Improvement Committee Meetings, which will include review of any outstanding Plans of Correction and Performance Improvement Plans. Will also include discussion and review of any high risk areas for potential system failures which require a plan to address. District Director of Clinical Services to review Quality Assurance and Performance Improvement Minutes for next three months and attend meetings when possible. QAPI will be held a minimum of quarterly thereafter.	