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	345115	A. BUILDING ______ B. WING ______	C 10/06/2017

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BRIAN CTR HEALTH & REHAB/SALISBURY	**635 STATESVILLE BOULEVARD SALISBURY, NC 28144**

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/02/17 through 10/06/17. Past-noncompliance was identified at: CFR 483.12 at tag F223 at a scope and severity (J) The tags F223 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 223 SS=J	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to protect a resident's right to be free from physical abuse for one of three residents reviewed for abuse (Resident # 124). Resident # 124 was struck on the left cheek by a staff member which caused a red mark to the left cheek of Resident # 124.	F 223	Past noncompliance: no plan of correction required.	10/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/30/2017

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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Findings included:

Resident # 124 was readmitted to the facility on 06/01/2017. The Resident's admission diagnoses included dementia, major depression, symbolic dysfunctions (also known as social impairment which is a broad range of social problem behaviors including difficulties in understanding social information, inability to adjust behavior to fit in social situations, reduced social interest, and lack of meaningful relationships), insomnia and Alzheimer's disease.

A quarterly Minimum Data Set (MDS) dated 07/04/2017 assessed Resident # 124 with severe cognitive impairment, disorganized thinking that did not fluctuate, had 1 to 3 days of physical behaviors toward others and 4 to 6 days of verbal behaviors toward others. Resident # 124 required extensive assist of 2 staff members with bed mobility, transfers, dressing and personal hygiene. Resident # 124 received scheduled pain medications and received antianxiety medication for 7 days of the review period and antidepressant medication for 2 days of the review period.

A care plan originally dated 01/23/2017 and updated most recently on 07/04/2017 recorded that Resident # 124 exhibited behaviors that included yelling and screaming at staff, hitting and kicking at staff and spitting at staff. The care plan goal was that Resident # 124 would verbalize the need to control abusive behavior through the next review date. The care plan's interventions included the following: administer medications as ordered and to observed and document for side effects and effectiveness, assess coping skills and support system, assess Resident # 124's

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F 223	Continued From page 2 understanding of the situation and allow time for the Resident to express self and feelings toward the situation and to observe and document behavior and attempted interventions, provide positive feedback for good behavior and attempted interventions, psychiatric consult as needed and when Resident # 124 became agitated to intervene before agitation escalated by guiding away from source of distress, engage calmly in conversation and if response is aggressive the staff was to walk calmly away and approach later. On 10/03/2017 at 2:42 PM, an observation was made of Resident # 124, Resident # 124 was quietly sitting in his wheelchair in the doorway of his room. There were no observed signs of redness or bruising to Resident # 124's face or arms. A written statement by Nursing Assistant (NA) #2 dated 09/01/2017 at 11:17 PM revealed that she had been in Resident # 124's room with NA #1 and had turned her back to look for a gown when she heard NA #1 say to Resident # 124 not to hit her and NA #2 heard what she thought was a slap and NA #1 stated, "you get what you give." NA #2 left the room and reported to Nurse # 1. On 10/05/2017 at 12:05 PM an interview was conducted with NA #2. NA #2 revealed that she had been assigned to Resident # 124 and that she had asked NA # 1 to assist putting him to bed and Resident # 124 started to yell at them and when NA #2 turned her back to NA #1 and Resident # 124 to look for a gown, NA #2 heard a slap and when NA #2 turned back around a red mark was observed on the left side if Resident # 124's face. NA #2 revealed that she left the room	F 223		

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immediately and reported to Nurse #1 what she had thought happened. Nurse #1 went to the Resident's room and told NA # 1 to leave the Resident's room and the Nurse #1 and NA #2 finished providing care. NA #2 revealed that all staff were aware that Resident # 124 could be aggressive during care and that sometimes he spit at staff, but that Resident # 124 had never slapped any staff member that she was aware of. NA #2 stated that she did not see NA #1 after the incident and that the Administrator and a police officer came to the facility and interviewed her. NA #2 added that Resident # 124 did not act scared of NA # 1 when they started to provide care to him. NA #2 stated that the NAs and the resident were Resident # 124's room and he had been sitting in his wheel chair when this happened. NA #2 also revealed that it was common for Resident # 124 to yell at staff during care.

A nurse progress note dated 09/02/2017 at 1:36 AM written by Nurse #1 revealed that Resident # 124 was involved in an altercation at 9:30 PM on 09/01/2017. A reddened area was noticed on Resident # 124's left cheek with no complaint of pain and no signs of distress observed. Resident # 124's vital signs were stable; the family of Resident # 124 was notified and the physician was notified. Resident # 124 was alert in bed and was listening to music.

A review of a written statement by Nurse #1 dated 09/01/2017at 11:30 PM revealed that NA #2 reported to the nurse that NA #1 had "hit" resident # 124. Nurse #1 reported to the nurse supervisor (Nurse #3), excused NA #1 from the room of Resident # 124 and assessed Resident # 124 with redness to the left cheek, but no bruising.

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NA #2 had reported that her back was turned to NA #1 and Resident # 124 and that NA #2 heard a slap and NA # 1 stated to Resident # 124, "you get what you give."

During an interview with Nurse #1 on 10/05/2017 at 7:46 AM Nurse # 1 revealed that NA # 2 had reported to her that she heard NA #1 slap Resident # 124 and that NA #1 had told Resident # 124 that "you get what you give." Nurse #1 immediately removed NA #1 from the room of Resident # 124 and called the nurse supervisor (Nurse #3) and reported what had been reported by Na #2.

A review of a written statement by Nurse #3 on 09/02/2017 at 12:08 AM revealed that Nurse #1 had reported that NA #2 had heard NA #1 slap Resident # 124 and Nurse #3 called the administrator to inform him of what had been reported. Nurse #3 also assessed Resident # 124 and observed that the left cheek of Resident # 124 was more red than the right cheek. Nurse # 3 then called the facility administrator to explain what had happened and Nurse #3 had NA #2 show her exactly where NA #1 and Resident # 124 were when NA # 2 heard a slap.

On 10/05/2017 at 2:23 PM an interview was conducted with Nurse #3 which revealed that she was the nurse supervisor on 09/01/2017 and that Nurse #1 had reported to her that NA #2 was very upset and had stated that NA #1 may have slapped Resident # 124 in the face when NA #1 and NA #2 were getting Resident # 124 ready for bed. Nurse #1 had removed NA #1 from the room of Resident # 124 and Nurse # 3 went to assess Resident # 124 and observed a red area to his left cheek and Nurse #3 had NA #2 re- enact

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what she (NA #2) had seen and heard when NA #1 and NA #2 were in the room of Resident # 124. Nurse # 3 called the administrator and was told to take NA #1 to the conference room and to remain there until the administrator came to the facility. Nurse # 3 took NA #1 to the conference room and remained there until the administrator and a police officer arrived at the facility. Nurse #3 revealed that she had begun all staff in-servicing for abuse and abuse prohibition as per the facility's policy as soon as the Administrator arrived at the facility.

A review of a written statement by NA #1 dated 09/02/2017 at 12:16 AM revealed that Resident # 124 had been yelling and hitting at staff. NA #1 placed her hand on the hand of Resident # 124 to try to calm him. NA #2 went to get a gown and when NA #1 removed Resident # 124's shirt, he spit at her and NA #1 covered his mouth so he would not spit and stated to Resident # 124, "sometimes you get what you deserve." NA #1 revealed that she had covered Resident # 124's mouth to stop him from spitting again, but that NA #1 did not mean to be so forceful.

On 10/05/2017 at 10:38 AM an attempt was made to reach NA #1 for an interview and the telephone number was not accepting calls at that time and voice mail was unavailable.

Review of Health Care Personnel Registry (HCPR) 24 Hour Initial Report dated 09/01/2017 completed by the Administrator recorded that on 09/01/2017 at 9:30 PM, NA #1 was reported to have slapped Resident # 124 in the face and that a report had been filed with the Police Department at 10:50 PM.

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F 223	Continued From page 6 Review of the Incident / Investigation Report completed by the Police Department dated 09/01/2017 at 10:51 PM revealed the crime of Simple Physical Assault had been committed at the facility with no injury observed and further investigation to be completed. Witnesses included NA #2, Nurse #1 and Nurse #3. A review of a written statement by the facility Administrator dated 09/02/2017 at 12:51 AM revealed that on 09/01/2017 at approximately 9:30 PM, the Administrator had received a call from Nurse #3 that an allegation of abuse had been made by NA #2 that NA #1 had slapped a Resident. The Administrator instructed Nurse #3 to remove NA #1 from Resident care areas and to remain with NA #1 in the conference room until the Administrator arrived at the facility. The Administrator arrived at the facility at 10:50 PM and called 911 to have an officer dispatched to the facility and a 24 Hour Report was submitted to the State. A police officer arrived at approximately 11:10 AM and began interviewing all staff members involved which he concluded at approximately 12:30 AM. The officer stated no arrest would be made at that time, but that the information would be presented to the District Attorney on 09/05/2017 and that the officer suspected that there was enough evidence for a misdemeanor assault on a handicap person charge. NA #1 was suspended pending further investigation. The police officer and Administrator escorted NA #1 out of the facility. After the officer exited the facility, Nurse #3 was instructed to begin all staff in-services and reeducation on abuse, neglect prohibition, non - violent behavior interventions and behavior management and that education would continue throughout the weekend and into the upcoming week until all	F 223		

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staff was reeducated prior to working their next scheduled shift.

Review of the HCPR 5 Working Day Report dated 09/11/2017, completed by the Administrator reported that NA #1 was suspected of Resident abuse on 09/01/2017 at 9:30 PM which resulted in physical injury/harm and that a report to the facility from the Police Department revealed that NA #1 was charged with Misdemeanor Assault on a handicap person. Na #1 had been terminated from employment from the facility on 09/02/2017.

The facility Administrator provided all staff in-service documentation dated 09/02/2017 through 09/05/2017 that included a summary of the abuse allegation, types of abuse, a root cause analysis of staff burn out, review of the Storms of Life Employee Assistance Program, the HAND In Hand and patient centered care program and a review of signs of staff burn out. On 09/07/2017 through 09/15/2017 repeated in-servicing was provided to all staff to engage staff in topics of abuse and staff burn out.

On 09/06/2017, the facility interviewed cognitively intact residents for abuse and neglect concerns and interviewed family members of cognitively impaired residents for abuse and neglect concerns with no concerns identified. This was confirmed by review of audit forms supplied by the facility on 10/04/2017 and 10/05/2017.

On 10/06/2017 at 10:44 AM an interview was conducted with the Director Of Nurses (DON) which revealed that all staff had been educated on 09/01/2017 through 09/05/2017 to attend Hand In Hand education to be presented to all staff on 10/17/2017 through 10/20/2017 and to

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walk away from any situation, even to stop providing care and to report to the nurse that they felt they needed a break and needed to deescalate a situation of concern for staff to resident interaction. When the DON stated that staff burn out was being addressed by the facility by changing staff assignments or allowing for time off from work if needed to address any concerns with staff burn out and new employees were also educated that the facility wanted to provide support and that any concerns could be discussed with a member of the management team in a private and confidential manner. The DON revealed that the expectation was that all staff be monitored for burn out or for possible personal life conflicts and that all staff provide support to one another to prevent a professional crisis from happening as it had in this specific instance.

An interview conducted with the Administrator on 1 0/06/2017at 2:23 PM revealed that and ad - hoc QA/PI (Quality Assurance/ Performance Improvement) had been added to the weekly QA meeting and that the facility expectation was to prevent resident abuse and to be more aware of staff burn out and how to provide assistance to staff members to deal with burn out and that it would be expected that the facility assist all staff members if they had concerns of burn out to prevent any future staff to resident altercations. The facility had not been aware that NA #1 had needed assist or had suffered from staff burn out, but the facility was now making an effort to make certain that all staff was aware of resources available for them to use if they felt they needed support from outside of the facility. The Administrator revealed that the root cause of the abuse allegation was determined to be from NA

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#1 having had multiple personal concerns that caused her to become frustrated with in her job description.

The facility provided a plan of correction with a correction date of 09/05/2017. The plan of correction included: F223
1.On 9/1/2017 at approximately 9:30pm the second shift Supervisor contacted the Administrator via phone to report an allegation of physical abuse. NA #2 alleged that NA #1 slapped Resident # 124 while providing care. She went on to describe that Resident #124 spat at NA #1 while providing assistance with ADLs and NA #2 slapped Resident #124's face.

NA #1 was immediately removed from Resident #124's Room by the Charge Nurse.

The Administrator instructed the 2nd Shift Supervisor to escort NA #1 to the conference room and remain with NA #1 until the Administrator arrived at the facility. NA #1 received one on one monitoring by the 2nd Shift Supervisor until all interviews were completed and she left the facility.

The Administrator arrived at the facility, contacted 911, and a Police Officer was dispatched to facility. The Police report was completed by the Officer. NA #1 was suspended by the Administrator pending further investigation.

The Administrator completed and submitted a 24-hour report to NC Healthcare Personnel Registry on 09/01/2017 at 10:01pm.

A Nursing assessment was completed by the Charge Nurse and the Second Shift Supervisor

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for Resident #124 with no injuries identified. He was noted by the Charge Nurse to be sleeping quietly following the event.
The Physician, Medical Director, and Responsible Party for Resident #124 were notified regarding the event by the Administrator on 09/01/2017 at 10:30pm.

Emotional support was provided to Resident #124 and his Responsible Party by the Administrator on 09/01/2017 with ongoing follow up and support provided by Social Services.

2. Further investigation reveals the following regarding NA # 1.
NA #1 began employment on 06/14/2007. NA #1 had a completed background check on 06/07/2007 which met criteria for employment.
The associate attended general orientation on 06/15/2007 with education received on abuse and neglect as well as resident rights. The NA completed education related to abuse, neglect, resident rights, dementia, and dealing with patients with behaviors on 06/15/2007, 07/16/2008, 03/04/2009, 05/24/2010, 04/14/2011, 05/03/2011, 11/25/2013, 01/13/2014, 05/16/2014, 03/21/2016, 06/02/2017, 07/26/2017 and 08/23/2017.

Last abuse education prior to allegation for NA #1 was completed on0 08/23/2017 by the Nursing Supervisor.
NA #1 had no previous allegations of abuse or corrective actions related to customer service or abuse in employee file.
Residents assigned to NA #1 were interviewed verbally by the Administrator related to abuse allegations involving NA #1 with no concerns noted. This audit was completed by 09/01/17.

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On0 9/05/2017 an ad-hoc QA/PI meeting was held to discuss the outcome of the investigation of this abuse allegation with the QA/PI Committee.

On 09/06/2017 additional abuse and neglect audits were completed with cognitively intact residents and families of cognitively impaired residents, by assistant administrator, social worker, and nurse manager. No new allegations were identified.

On 09/07/2017 an additional ad hoc QA/PI meeting was held to conduct further root cause analysis related to potential staff burnout and stress as a cause for resident abuse.

3. On 09/01/2017 all facility staff including Nursing, Housekeeping, Dietary, Social Services, and Administration were re-educated by Nurse Supervisors regarding abuse prevention and dealing with behaviors. This was initiated immediately and continued until all staff were re-educated prior to returning to work.

CMS (Center for Medicare and Medicaid Services) Hand-In-Hand and staff burnout education was scheduled during the QA/PI meeting on 09/07/2017 and completed with 6 sessions accommodating all shift on 09/12/2017-09/15/2017 for all facility staff related to preventing abuse, dealing with specific patient behaviors to include no retaliation against residents who exhibit behaviors, promoting person-centered care, alternative strategies to promote positive interactions with patients who are exhibiting behaviors (tag out, take a break, try later, step into their world, etc.) and associate

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F 223	Continued From page 12 burnout Additionally the education included group discussion about our specific patients and their specific behaviors. CMS Hand-In-Hand education and education about our specific patients and their specific behaviors is ongoing monthly for all staff and monthly associate meetings scheduled to discuss concerns with work environment or burnout. 10 random cognitively intact residents and the family members of cognitively impaired residents will be interviewed weekly regarding allegations of abuse by the Administrator, DON or Nursing Supervisors beginning on 09/01/2017. If any adverse outcomes are identified via the weekly audit, immediate action will be taken, to include reporting incident via 24-hour report. 4. The results of the weekly audits will be reported by the Administrator in the weekly Quality Assurance and Performance Improvement Committee meeting, recommendations will be made by the committee to maintain compliance. Compliance achieved 09/05/2017. The corrective action plan was validated on 10/06/2017. Validation included interviews with randomly chosen residents and resident family members which revealed there were no concerns of abuse to residents in the facility and to report abuse immediately to facility staff or management. Validation included interviews of 5 randomly chosen front line staff interviewed on 10/03/2017 through 10/05/2017 which included validation of	F 223		

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F 223	Continued From page 13 recent in-service education for types of abuse, abuse prevention, reporting abuse and recognizing and reporting signs of staff burn out. Interviews conducted with 3 department managers was conducted on 10/03/2017 through 10/05/2017 which included validation of recent in-service education for types of abuse, abuse prevention, reporting abuse and recognizing and reporting signs of staff burn out. On 09/01/2017 the facility had initiated random audits of interviews of 10 residents for abuse, abuse reporting and recognizing and reporting signs of staff burn out to the facility. Cognitively intact residents were audited and family members of cognitively impaired residents were audited. The facility had educated all staff to recognize and report any signs of staff burn out and the staff had been provided with materials of out sourced entities available to the staff to deal with staff burn out. The facility had also scheduled Hand In Hand mandatory education for all staff to begin on 10/17/2017, 10/18/17,10/19/2017 and 10/20/2017. Town Hall meetings had been scheduled for the residents, families and community starting on 10/25/2017,11/14/2017 and 12/12/2017.	F 223		
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.	F 282		11/3/17

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and record review the facility failed to follow interventions according to the care plan for 1 of 3 residents (Resident #56) to provide soft bilateral finger cushion during the day.

Findings included:

Resident #56 was admitted to the facility on 9/27/11 with a diagnosis that included anoxic brain damage, convulsions, pressure ulcer of left lower back (stage 3), tracheostomy, gastrostomy status, and persistent vegetative state. Most recent Minimum Data Set (MDS) dated 7/7/17 revealed Resident #56 had upper body impairments and required extensive assistance for Activities of Daily living (ADL). The MDS further revealed Resident #56 was severely cognitively impaired.

Review of Resident #56 physician order dated 5/4/17 revealed staff to apply bilateral finger contracture cushion for daytime use. The physician order further stated may be removed for bathing and skin integrity.

Review of Resident #56 care plan dated 8/7/17 revealed a problem of ADL's with a focus of self-care performance deficit related to total care needed with all ADL's due to coma. The focus continued with contractures noted to bilateral hands. The goal stated Resident #56 would not suffer further complications related to immobility. The interventions included left and right hand finger contracture cushions per Medical Doctor (MD) order.

Brian Center Health & Rehabilitation/Salisbury acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance.

Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on October 2-6, 2017. Brian Center Health & Rehabilitation/Salisbury□s response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, the Brian Center Health & Rehabilitation/Salisbury reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures.

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1. Resident #56 care plan updated by the Resident Care Management Director on 11/3/17, to include guidance for the application of bilateral finger contracture cushions. Licensed and Certified Nursing staff re-educated Director of Nursing and Assistant Director of Nursing on the

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F 282	Continued From page 15 Review of Resident #56 care guide revealed no guidance for contracture management or the application of bilateral finger contracture cushions. Interview with NA #10 on 10/3/17 at 2:41pm revealed she worked first shift and Resident #56 was a part of her assignment. NA #10 stated she was not aware of Resident #56 having "hand rolls" on hands for contractures and was not sure if these devices were on Resident #56 care guide. Interview with NA #4 on 10/4/17 at 3:25pm revealed on second shift NA #4 had seen Resident #56 with hand rolls at times. She stated she was not aware of when Resident #56 hand rolls were to be put on her or taken off. NA stated she assumed hand rolls were on Resident #56 if needed and not on if Resident did not need them. Interview with Nurse #4 on 10/4/17 at 4:20pm reviewed physician order in electronic medical record (EMR) but unable to find order for applying bilateral finger contracture cushion during the day, on treatment administration record (TAR) or medication administration Record (MAR). Nurse #4 was unaware of who was responsible for applying Resident #56 bilateral finger contracture cushions. Interview with OT on 10/5/17 at 3:51pm revealed that she was familiar with Resident #56 and remembered performing an evaluation and giving recommendations for bilateral finger contracture cushions and splints for Resident #56 hands several months ago. OT evaluation done per nursing staff's concern that Resident #56 hand contractures not worsen. She stated she taught	F 282	updates to the care plan by 11/3/17. 2. Current residents with contractures have the potential to be affected by the alleged deficient practice. All care plans for residents with contractures were updated by Resident Care Management Director to reflect care plan goals and personal preferences by 11/3/17. 3. Licensed and Certified Nursing Staff will be re-educated by Director of Nursing and/or Staff Development Coordinator regarding care plan goals and personal preferences being reflective on individual care plans. Education to be completed by 11/3/17. Nurse Managers and MDS Nurses will monitor 5 residents with contractures per week for 12 weeks to ensure residents□ daily care is reflective of resident□s individual care plan goals and personal preferences. Opportunities will be corrected as identified. 4.Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Resident Care Management Director monthly for 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 282	Continued From page 16 floor staff how to correctly apply splints and finger contracture cushions on 5/4/17. No follow up to verify correct use of splints and finger contracture device cushions. She stated that it was her expectation that splints and finger cushions continue to be used as ordered. She said she had not been made aware of any problems or changes with resident's hand contractures or treatment.	F 282		
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 observations, record review, and staff interviews the facility failed to perform incontinent care (Resident #78) and failed to clean and trim dirty fingernails (Resident #65) for 2 of 5 dependent residents sampled for activities of daily living. The findings included: 1. Resident #78 was re-admitted to the facility on 08/09/16 with diagnoses that included: dementia, chronic obstructive pulmonary disease, anemia and macular degeneration. Review of the most recent quarterly minimum data set (MDS) dated 08/15/17 revealed that Resident #78 was severely cognitively impaired for daily decision making and required extensive assistance with personal hygiene.	F 312	F312 1. Incontinence care provided to Resident #78 NA #5 on 10/2/17. Resident #65 fingernails were trimmed and cleaned on 10/6/17 by Nurse #7. 2. All residents requiring assistance with ADLS have the potential to be affected by the alleged deficient practice. Unit Managers completed an audit of all dependent residents□ fingernails to ensure cleanliness of nails and that nails were trimmed. Audit completed by 10/27/17. Opportunities were corrected as identified. 3. Licensed and Certified Nursing staff will be re-educated Director of Nursing and/or Assistant Director of Nursing on	11/3/17

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F 312	Continued From page 17 Review of a care plan revised on 07/06/17 indicated that Resident #78 was at increased risk for urinary tract infection related to her history of urinary tract infections and her incontinence of bowel and bladder. The goal was to minimize Resident #78's risk of septicemia by prompt recognition and treatment of symptoms. The interventions included: encourager fluid intake and Resident #78 required assistance with incontinence care during care rounds and as needed. Review of Resident #78's physician order summary revealed that Resident #78 was on Lasix (diuretic) 20 milligrams (mg) by mouth every day for edema. An observation and interview was conducted with Resident # 78 on 10/02/17 at 3:17 PM. Resident #78 was up in wheelchair at bedside. There was a urine odor detected while sitting approximately 2 feet from the resident. When asked if she was soiled Resident #78 replied "yes I just could not hold it any longer, I am so sorry." Resident #78's call bell was turned on. A continuous observation was made of Resident #78 on 10/02/17 at 3:19 PM. Staff responded to the call bell and stated they would return to provide incontinent care. The urine odor was still detected from 2 feet from the resident. At 3:29 PM Nursing Assistant (NA) #5 returned to Resident #78's room to provide incontinent care. NA #5 stood Resident #78 up from her wheelchair to transfer her to bed and the urine odor became much more prevalent from 3 feet away. NA # 5 stated "wow you are really wet and have not been changed in a while." NA #5 proceed to provide incontinent care and stated that she had just	F 312	proper cleanliness and trimming of lengthy fingernails of dependent residents and ADL care by 11/3/17. Unit Managers will conduct audits of 10 random dependent residents to ensure proper ADL care is being provided and lengthy fingernails are trimmed and cleaned. These audits will be conducted weekly for 12 weeks. Opportunities will be corrected as identified. 4. Director of Nursing and/or Assistant Director of Nursing or designee will review results the audits. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI weekly x 12 weeks, at which time the QAPI committee will evaluate the effectiveness of the interventions and make recommendations to determine if further auditing is needed to sustain compliance ongoing.	

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arrived for her shift at 2:00 PM and this was the first time she had provided any care to Resident #78 since arriving for her shift that day. The pad that Resident #78 was sitting on was visibly soiled, her black pants that she was wearing were visibly wet with a large wet ring that extended from her lower back to her mid-thigh region. The brief was heavy and the inner absorbent contents had all bunched together from the excessive moisture.

An interview was conducted with NA #6 on 10/04/17 at 9:20 AM. NA #6 confirmed that she cared for Resident #78 on 10/02/17 on 1st shift. NA #6 stated that Resident #78 was dependent on staff for all activities of daily living and was incontinent and had to be changed every 2 hours. NA #6 stated that she had last changed Resident #78 on 10/02/17 at 12:30 PM and she was a "little bit wet", she added that Resident #78 stated that at times she would be dry and then at times "she will flood out."

An interview was conducted with NA #11 on 10/05/17 at 1:29 PM. NA #11 stated she routinely cared for Resident #78 and she was incontinent of bowel and bladder. NA #11 stated that each time you check Resident #78 she was wet and at times she was a "heavy wetter". She added that she routinely rounded on Resident #78 when she arrived for her shift in the morning and then after breakfast and before and after lunch and each time Resident #78 would be wet and would require a brief change but generally she was not wet through her clothes that would require them to be changed.

An interview was conducted with the Director of Nursing (DON) on 10/05/17 at 3:32 PM. The DON

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F 312	Continued From page 19 stated that each resident was to be checked and changed frequently more specifically before/after meals and at bedtime. The DON stated she was not familiar with Resident #78's voiding pattern but she would never want a resident to be sitting soaked in urine. An interview was conducted with NA #7 on 10/06/17 at 8:43 AM. NA #7 stated that she cared for Resident #78 only occasionally and that at times Resident #78 was a heavy wetter and at times soaked her brief and clothes. NA #7 stated that when she cared for Resident #78 she would check and change her at least 3 times but because she was a "heavy wetter" Resident #78 needed to be checked and changed more frequently than every 2 hours. NA #7 that the facility utilized the Resident Care Specialist Assignment sheet to provide the NAs with details on how to care for each resident and that the form indicated only that Resident #78 was incontinent and what size brief she wore. 2. Resident #65 was recently readmitted to the facility on 06/09/17 with diagnoses that included: dementia, Alzheimer's disease, heart failure, and hypertension. Review of the most recent quarterly minimum data set (MDS) dated 08/04/17 revealed that Resident #65 was moderately impaired for daily decision making and required total assistance of one staff member for personal hygiene and extensive 2 person assistance with feeding. An observation of Resident #65 was made on 10/02/17 at 12:13 PM. Resident #65 was resting in bed with 6 fingernails that were a quarter inch long and had dried brown substance under them.	F 312		

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An observation of Resident #65 was made on 10/03/17 at 2:53 PM. Resident #65 was resting in bed with 6 finger nails that were a quarter inch long and had dried brown substance under them.

An observation of Resident #65 was made on 10/04/17 at 2:19 PM. Resident #65 was resting in bed with 6 finger nails that were a quarter inch long and had dried brown substance under them.

An interview was conducted with Nursing Assistant (NA) #8 on 10/04/17 at 2:57 PM. NA #8 stated that she routinely cared for Resident #65 and she received a bed bath 2 times a week and that her nails should be trimmed and cleaned during that time. NA #8 observed Resident #65's nails and stated "those definitely need to be trimmed and cleaned out" she added that Resident #65 did not resist care and that would she "would get on getting her nails cleaned out." NA #8 stated she had been on vacation for the last week and this was her first day returning to care for Resident #65.

An observation of Resident #65 was made on 10/05/17 at 9:29 AM. Resident #65 was up in wheelchair at bedside. There were 6 fingernails that were a quarter inch long that had dried brown substance under them.

Review of Resident #65's medical record revealed no documentation of refusal or resistance of nail care.

An interview was conducted with Nurse #7 on 10/06/17 at 8:31 AM. Nurse #7 stated that she routinely worked with Resident #65 and she expected the NAs to clean and trim resident's

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F 312	Continued From page 21 nails whenever they see they are dirty/long but especially during their shower or bath times. Nurse #7 added that if the resident was a diabetic then the NAs are expected to alert the nurse and the nurse would trim them. An observation of Resident #65 was made on 10/06/17 at 9:26 AM. Resident #65 was up in wheelchair at bedside. There were 6 fingernails that were a quarter inch long and had dried brown substance under them. Attempts to conduct a follow up interview with NA #8 on 10/06/17 at 10:00 AM was unsuccessful. An interview was conducted with the Director of Nursing (DON) was conducted on 10/06/17 at 12:01 PM. The DON stated that she expected the NAs to observe nails and provide care during the residents scheduled bath time but they could actually do it at any time. She further stated that if the resident ate with her hands then she would expect nails to be cleaned after meals time. Also if the resident dug in feces then most definitely their nails should be cleaned.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum	F 318		11/3/17

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practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interview the facility failed to apply physician ordered left knee splint (Resident #101) and a soft finger cushion during the day (Resident #56) for 2 of 2 residents sampled for range of motion.

The findings included:

1. Resident #101 was most recently readmitted to the facility on 01/28/16 with diagnoses that included: hemiplegia, hypertension, cerebral infarction, and peripheral vascular disease.

Review of a Physical Therapy (PT) discharge summary dated 03/31/16 revealed that Resident #101 had -85 degrees of extension to his left knee and was tolerating 4 hours of left knee extension splint for 4 hours.

Review of a physician order dated 08/16/16 read, left knee splint when up in chair as tolerated.

Review of a care plan initiated 02/29/17 read in part, Resident #101 had an ADL self-care performance deficit related to hemiplegia from a cerebrovascular accident and was admitted with a contracted left knee. The goal of stated care plan was Resident #101 would have his needs met through the next review date. The interventions included air mattress and left knee splint.

Review of a PT discharge summary dated 07/05/17 revealed that Resident #101 had -135 degrees of extension to his left knee and the left

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1. PT and OT evaluation completed on 10/23/17 for residents #101 and #56 to evaluate the need for continued orthopedic devices.

2. Current residents with orthopedic devices have the potential to be affected by the alleged deficient practice. PT and OT will re-assess all residents with current orders for orthopedic devices to determine the need for continued orthopedic devices. The Rehab Manager will coordinate these assessments and will be completed by 10/27/17.

3. Licensed and Certified Nursing staff will be re-educated by the Rehab Program Manager on the proper donning and removal of orthopedic devices by 11/3/17.

Nurse Managers will randomly audit 5 residents with splints weekly for 12 weeks to ensure orthopedic device application is per physician□s order. Opportunities will be corrected as identified.

4.Data obtained during the audit process will be gathered and analyzed for patterns and trends. The information will be reported to QAPI by the Rehab Manager monthly for 3 months at which time the committee will be evaluating the effectiveness of the interventions and

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F 318	Continued From page 23 knee extension splint was not appropriate at that time given his poor progress with the goals and the extensive and advanced debility and contractures. Review of the most recent quarterly minimum data set (MDS) dated 08/29/17 revealed that Resident #101 was moderately cognitively impaired for daily decision making and required extensive to total assistance with activities of daily living (ADLs). The MDS also revealed that Resident #101 had impairment one upper/lower extremity. Review of PT Evaluation and Plan of Treatment dated 09/25/17 indicated that Resident #101's left hip, knee and ankle were impaired and stated that skilled therapy was not needed to address the impairment because Resident #101 had chronic lower extremity contracture with poor outcomes with prior PT interventions. Review of Medication Administration Record (MAR) dated 10/01/17 through 10/31/17 revealed the following: Left knee splint when up in chair as tolerated every day for preventative care. This was initialed daily as being applied each day. Review of Resident #101's medical record revealed no refusal of the splint ordered for his left knee. An observation of Resident #101 was made on 10/02/17 at 12:13 PM. Resident #101 was resting in bed with both legs contracted where his heels where resting between his legs just below his buttocks. There was an air boot in place to the right foot. No pillows were noted between his legs or knees. No splinting devices were noted on	F 318	determine the need for further auditing in order to sustain compliance.	

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Resident #101 or could be located in his room. Resident #101 indicated by shaking his head that he was not in any discomfort.

An observation of Resident #101 was made on 10/03/17 at 8:44 AM. Resident #101 was resting in bed with both legs contracted where his heels where resting between his legs just below his buttocks. There was an air boot in place to the right foot. No pillows were noted between his legs or knees. No splinting devices were noted on Resident #101 or could be located in his room. Resident #101 indicated by shaking his head that he was not in any discomfort.

An interview was conducted with the PT on 10/03/17 at 4:11 PM. The PT stated that he had evaluated Resident #101 on 09/25/17 due to a new wound that had developed. He added that although he was not evaluating Resident #101 left lower extremity contracture he felt like the left lower extremity had definitely gotten worse from July to September 2017. He explained that Resident #101 used to allow his legs to be stretched out and this time he would not allow me to touch his legs at all and was in pain when any type of range of motion was attempted.

An observation and interview was conducted with Resident #101 on 10/04/17 at 8:58 AM. He was resting in bed and was very alert. Resident #101 stated that at times the staff would put him in his chair and "it feels good when they get me up" and he stated that he does not wear any splints on his legs. Resident #101's legs were contracted where his heels where resting between his legs just below his buttocks. There was no pillow noted between his legs/knees and no splinting devices were present on him nor could they be located in

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his room.

An interview was conducted with Nursing Assistant (NA) #12 on 10/04/17 at 10:10 AM. NA #12 stated that routinely cared for Resident #101 and provided total assistance with his ADLs. She added that she turned Resident #101 at least every 2 hours and I try to put a pillow between his legs and he wears an air boot on his foot. NA #12 stated that she had never seen any splinting devices or anything on his legs just the boot on his foot.

An observation of Resident #101 was made on 10/04/17 at 11:22 AM. Resident #101 was up in a geri chair at bedside. Both legs were contracted where his heels were resting between his legs just below his buttocks. Nurse #4 was observed trying to get a pillow between Resident #101's knees and she was unable to get his knees separated enough to get the pillow between them. Nurse #4 was observed to get a thin flat sheet between Resident #101's knees. There was no splint device on Resident #101 nor could one be located in his room.

An interview was conducted with Nurse #4 on 10/04/17 at 11:22 AM. Nurse #4 stated that she was an agency nurse and had only been coming to the facility for about 2 weeks. She stated that Resident #101 had a knee splint that he wore while he was up in his chair but only as he tolerated. Nurse #4 stated that the staff did try to apply the splint to Resident #101's left leg each day but he was just not able to wear it.

An observation of Resident #101 was made on 10/04/17 at 2:22 PM. Resident #101 was resting in bed on his abdomen with his head facing the

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window and both legs were contracted where both heels were resting between his legs just below his buttocks. There was an air boot in place to the right foot. No pillows were noted to be between his legs/knee/feet. No splinting devices were present on Resident #101 and none were located in his room.

Review of a care plan that was revised on 10/04/17 read in part, Resident #101 had an ADL self-care performance deficit related to hemiplegia from a cerebrovascular accident and was admitted with a contracted left knee. The goal of stated care plan was Resident #101 would have his needs met through the next review date. The interventions included: left knee splint as ordered. This intervention was added to the care plan 03/31/16. The revision made on 10/04/17 did not alter the interventions that addressed Resident #101's contracture.

An observation of Resident #101 was made on 10/05/17 at 9:25 AM. Resident #101 was up in a geri chair at bedside. Both legs were contracted where his heels were resting between his legs just below his buttocks. There was no splint device on Resident #101 nor could one be located in his room. Resident #101 indicated he was not in any discomfort.

An interview was conducted with the Director of Nursing (DON) on 10/05/17 at 3:41 PM. The DON stated that Resident #101 had contractures since he had been at the facility for approximately 3 months. The DON stated that she expected some type of program to be in place to prevent the Resident #101's contractures from getting any worse. She also stated that she would expect his splint be applied as ordered and the staff should

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have alerted me that he was not able to wear the splint and I would have discontinued it. She further stated that Resident #101's decline was inevitable and there was nothing we could have done to prevent the decline.

An interview was conducted with Nurse #7 on 10/06/17 at 8:31 AM. Nurse #7 stated she routinely cared for Resident #101 on 2nd shift and she stated that he required total assistance of 1 or 2 staff members with turning and repositioning due to his contractures. She added that Resident #101 was turned at least every 2 hours and we are only able to roll him side to side and it was too painful to move him any other way. Nurse #7 stated that Resident #101 did not receive any range of motion and had no splints that she was aware of.

2. Resident #56 was admitted to the facility on 9/27/11 with a diagnosis that included anoxic brain damage, convulsions, pressure ulcer of left lower back (stage 3), tracheostomy, gastrostomy status, and persistent vegetative state. Most recent Minimum Data Set (MDS) dated 7/7/17 revealed Resident #56 had upper body impairments and required extensive assistance for Activities of Daily living (ADL). The MDS further revealed Resident #56 was severely cognitively impaired.

Review of Resident #56 care plan dated 8/7/17 revealed a problem of ADL's with a focus of self-care performance deficit related to total care needed with all ADL's due to coma. The focus continued with contractures noted to bilateral hands. The goal stated Resident #56 would not suffer further complications related to immobility.

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The interventions included left hand and right hand splints per
Medical Doctor (MD) order. The care plan was not specific to the need for bilateral finger contracture
Cushion.

Review of Resident #56 physician order dated 5/4/17 revealed staff to apply bilateral finger contracture cushion for daytime use. The physician order further stated may be removed for bathing and skin integrity.

Review of Resident #56 Occupational Therapy (OT) evaluation and plan of treatment dated 5/4/17 stated impaired range of motion (ROM) related to contracture. The recommendations included bilateral finger contracture cushion to be used during the day.

Review of Resident #56 care guide revealed no guidance for contracture management or the application of splint devices.

Observation of Resident #56 on 10/3/17 at 2:41pm revealed resident to be lying in bed with sheets
Covering upper and lower extremities. NA #10 was unable to straighten resident's fingers from a cupped position. Skin on hands clean and intact with no splints or other devices on hands.

Interview with NA #10 on 10/3/17 at 2:41pm revealed she worked first shift and Resident #56 was a part of her assignment. NA #10 stated she was not aware of Resident #56 having splints or hand rolls on hands for contractures and was not sure if these devices were on Resident #56 care guide.

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Observation on 10/04/2017 at 10:48am revealed Resident #56 lying in bed with no finger contracture
cushion or hand rolls on hands.

Interview with NA #4 on 10/4/17 at 3:25pm revealed on second shift NA #4 had seen Resident #56 with hand rolls at times. She stated she was not aware of when Resident #56 splints or hand rolls were to be put on her or taken off. NA stated she assumed splints or hand rolls were on Resident #56 if needed and not on if Resident did not need them.

Interview with Nurse #4 on 10/4/17 at 4:20pm reviewed physician order in electronic medical record (EMR) but unable to find order for applying bilateral finger contracture cushion during the day, on treatment administration record (TAR) or medication administration Record (MAR). Nurse #4 was unaware of who was responsible for applying Resident #56 splints or hand rolls.

Interview with the Therapy Manager on 10/5/17 at 8:18am revealed OT evaluated Resident #56 on 5/4/17 due to a concern from nursing in regards to Resident #56 hand contractures. He further indicated on 5/4/17 OT recommended hand splits and bilateral finger contracture cushion to be worn during the day. He continued that staff were provided training on how to apply splints by the therapy staff. The Therapy manager revealed it was his expectation that therapy treatments continue until a resident is re-evaluated or the order is discontinued.

Interview with OT on 10/5/17 at 3:51pm revealed that she was familiar with Resident #56 and

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F 318	Continued From page 30 remembered performing an evaluation and giving recommendations for bilateral finger contracture cushions and splints for Resident #56 hands several months ago. OT evaluation on 5/4/17 performed per nursing staff's concern that Resident #56 hand contractures not worsen. She stated she taught floor staff how to correctly apply splints and finger contracture cushions. She stated that it was her expectation that splints and finger cushions continue to be used as ordered. She said she had not been made aware of any problems or changes with resident's hand contractures or treatment.	F 318		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 322		11/3/17

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F 322	Continued From page 31 by: Based on observation, staff interview and record review the facility failed use gravity to administer medication and a pre and post medication water flush, to 1 of 1 residents with a feeding tube (Resident # 93) and failed to administer a water bolus as ordered for 1 of 1 residents with a feeding tube (Resident # 93). The findings included: Review of the facility Pharmacy and Procedures Manual policy dated 10/31/16 and titled "Medication Administration through an Enteral Tube" revealed "Facility should insert medication syringe in appropriate port. Remix medication and pour into medication syringe so entire dose is administered. Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube. Flush after each dose with at least 15 ml (milliliters) water." 1a. Resident #93 was admitted 10/28/16 with diagnoses including heart failure, seizure disorder, Diabetes Mellitus. Review of the 7/26/17 Quarterly Minimum Data Set (MDS) revealed Resident # 93 was cognitively impaired and had a feeding tube. On 10/4/17 at 3:22 PM Nurse #7 was observed administering medication and pre and post medication water flushes via Resident # 93 ' s feeding tube. After checking the placement of the tube, she put 15 ml (milliliters) of water in the barrel of a 50-ml syringe. She then used the syringe with its plunger to push the pre-medication water flush into the feeding tube. Nurse #7 proceeded to disconnected the syringe from the feeding tube, remove the plunger and	F 322	F322 1. Resident #93 received water bolus according to the physician□s orders. Nurse #7 received education by Staff Development Coordinator regarding the proper technique for administration of medications via gastrostomy tube on 10/4/17. 2. All residents with gastrostomy tubes have the potential to be affected by the alleged deficient practice. 3. Licensed Nursing staff will be re-educated by the Staff Development Coordinator regarding the proper technique for administration of medications via gastrostomy tube. This education completed by 11/3/17. 4. Nurse Managers will conduct random observations of 5 Nurses on varying shifts weekly for 12 weeks to validate proper techniques for administration of medications via gastrostomy tubes. Opportunities will be corrected as identified. Data obtained during the audit process will be gathered and analyzed for patterns and trends. The information will be reported to QAPI by the DON monthly for 3 months at which time the committee will be evaluating the effectiveness of the interventions and determine the need for further auditing in order to sustain compliance.	

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then put the liquid medication in the barrel of the syringe. After this she used the syringe with its plunger to push the medication into the resident ' s feeding tube. Next, Nurse #7 disconnected the syringe from the feeding tube and removed the plunger. She then put 15 ml water in the barrel of the syringe and used the plunger to push this post medication water flush into the feeding tube.

Interview with Nurse #7 on 10/4/17 at 3:46 PM revealed that she used the syringe to push the water flushes and medication because she had not been told that she couldn ' t. She also states that the liquid medication was thick and would stick to the sides of the feeding tube, making it difficult to drain into the tube without being pushed.

Interview with the Director of Nursing (DON) on 10/5/17 at 6:30 PM revealed that it was her expectation that water flushes and medications administered via feeding tube were administered by gravity.

1b. Resident #93 was admitted 10/28/16 with diagnoses including heart failure, seizure disorder, Diabetes Mellitus.

Review of the 7/26/17 Quarterly Minimum Data Set (MDS) revealed Resident # 93 was cognitively impaired and had a feeding tube.

On 10/4/17 at 3:30 PM Nurse #7 was observed administering a bolus of 125 ml (milliliters) water via a gravity to Resident # 93 ' s feeding tube. She then reconnected the resident ' s feeding tube to the tube feeding pump. The pump was observed to be programmed to provide the resident with his tube feeding formula as ordered

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at 60 ml / hr (milliliters per hour) as well as a water flush of 125 ml every 4 hours. Both the formula and water were hung and set up to run and be administered through the pump.

On 10/4/17 at 3:46 PM the water flush orders were reviewed with Nurse #7. She acknowledged that she could only locate one order for a water flush of 125 ml every 4 hours. The tube feeding pump was observed with Nurse #7 and she acknowledged that it was set to administer 125 ml water every 4 hours. Nurse #7 was interviewed at this time and stated that she thought that in addition to the flush that was being administered via the pump that the resident was to get an additional 125 ml every 4 hours via a gravity bolus.

On 10/4/17 at 4:30 PM the Director of Nursing was informed of the potential doubling of the water flushes for Resident #93. She indicated the facility would assess the resident and address any errors.

On 10/5/17 at 6:30 PM the Director of Nursing (DON) was interviewed. She stated that Resident #93 had gotten 1 extra water flush, as observed. The DON also reported that Nurse #7 had not been working on that medication cart previously and that the physician was contacted and indicated that there were no negative outcomes related to an extra 125 ml. The DON added that the event had been addressed as a medication error. She also said that she expected water flushes to be given as ordered and added that the Nurse should have known the water was already being administered through the pump but she was nervous and not thinking it through.

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F 431	Continued From page 34	F 431		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		11/3/17

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.

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F 431	Continued From page 35 (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications (100 hall, 300 hall Nurse Medication carts and 200 hall Medication Aide cart) and failed to store medication in its original packaging (100 hall Medication Aide Cart #1 and #2, 200 hall and 300 hall Medication Aide carts) for 6 of 7 Medication carts observed. The Findings included: 1a. An observation of the 100 Hall Nurse Medication Cart was conducted on 10/04/17 at 9:50 AM with Nurse #4 present. The following expired medications were noted: 1 card that contained 1 pill of hydroxyzine (antihistamine) that expired 09/30/17, 1 card that contained 1 pill of cyclobenzaprine (muscle relaxer) that expired 08/31/17, 1 card that contained 2 pills of hydrocodone (pain medication) that expired 09/22/17, 1 card of hydrocodone that contained 10 pills that expired 09/22/17, and 1 card of	F 431	F431 1. (a) Expired medications identified on the 100 hall and 300 hall Nurse Medication Carts and 200 hall Medication Aide Cart were removed and sent back to the pharmacy by Unit Manager by 10/5/17. (b) Loose pills were removed and discarded from 100 hall Medication Aide cart #1 and #2, 200 hall and 300 hall Medication Aide carts by Unit Manager by 10/5/17. (c) Pharmacy consultant notified by Director of Nursing on 10/27/17. 2. All residents have the potential to be affected by this alleged deficient practice. Nurse Managers conducted an audit of all medication carts by 10/27/17 to ensure all	

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	345115	A. BUILDING ______ B. WING ______	C 10/06/2017

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F 431	Continued From page 36 hydrocodone that contained 9 pills that expired 09/22/17. An interview was conducted with Nurse #4 on 10/04/17 at 10:02 AM. Nurse #4 stated that she would return the expired medications to the pharmacy and stated that every nurse went through the carts to check for expired medications but the formal cart audits were completed on 3rd shift. Nurse #4 indicated that she had not gone through her medication cart prior to starting her shift. 1b. An observation of the 200 Hall MA cart was conducted on 10/05/17 at 11:03 AM with MA #2 present. The following was noted on the cart: 1 card of catapres (antihypertensive) that contained 30 pills that expired 08/31/17. An interview was conducted with Nurse #5 on 10/05/17 at 11:03 AM who stated that she had just gone through the medication cart earlier in the day and did not identify the expired medication. 1c. An observation of the 300 Hall Nurse Medication cart was conducted on 10/05/17 at 12:46 PM with Nurse #6 present. The following was noted: 1 opened bottle of Vitamin D 400 units that expired 08/2017. An interview was conducted with Nurse #6 on 10/05/17 at 12:46 PM who stated that she had gone through her medication cart yesterday and did not identify the expired medication and she would dispose of the expired medication. An interview was conducted with the Director of Nursing (DON) on 10/06/17 at 12:01 PM. The	F 431	medications were labeled and dated and no loose pills or expired medications were observed. 3. Licensed and Certified Nursing staff who are responsible for medication administration will be re-educated by Director of Nursing and/or Staff Development Coordinator on dating and labeling medication and discarding loose medications by 11/3/17. Nurse Managers will perform randomly audit 4 medication carts weekly for 12 weeks to validate medications are labeled and dated and no loose pills or expired medications are stored in the medication cart. Opportunities will be corrected as identified. 4. Data obtained during the audit process will be gathered and analyzed for patterns and trends. The information will be reported to QAPI by the DON monthly for 3 months at which time the committee will be evaluating the effectiveness of the interventions and determine the need for further auditing in order to sustain compliance	

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F 431	Continued From page 37 DON stated that she expected every nurse and MA to go through their carts to check for expired medication. She added that 3rd shift was responsible for completing the medication audits and the pharmacy had been there in August 2017 and gone through the medication carts as well. The DON stated she expected all expired medication and loose pills to be removed from the medication carts and returned to the pharmacy for destruction. 2a. An observation of the 100 hall Medication Aide (MA) Cart #1 was conducted on 10/04/17 at 11:25 AM with MA #1 present. The following was noted: 1 square pill, 5 white round pills, 4 round half white pills, 1 half oblong pink pill, 2 square blue pills, 1 round yellow pill, 1 round beige pill, 1 oblong yellow pill, 1 green capsule, and 1 large round white pill. All the pills were loose in the bottom of the drawers on the medication cart. An interview was conducted with MA #1 on 10/04/17 at 11:25 AM. NA #1 stated she could not identify the medication and stated she would dispose of the loose pills. 2b. An observation of the 200 Hall MA cart was conducted on 10/05/17 at 11:03 AM with MA #2 present. The following was noted on the cart: 2 small round white pills loose and 1 round yellow pill loose in the bottom drawer of the medication cart. An interview was conducted with MA #2 on 10/05/17 at 11:03 AM who stated that she could not identify the loose pills and that she would dispose of them properly. 2c. An observation of the 100 Hall MA Cart #2	F 431		

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F 431	Continued From page 38 was conducted on 10/05/17 at 12:14 PM with MA #3 present. The following was noted: 2 round white pills, 1 red round pill, and 1 red capsule all loose in the middle drawer of the medication cart. An interview was conducted with MA #3 on 10/05/17 at 12:14 PM. MA #3 stated that she could not identify the loose pills and she would dispose of them. 2d. An observation of the 300 Hall MA cart was conducted on 10/05/17 at 12:56 PM with Nurse #6 present. The following was noted: 1 half blue pill, 1 half yellow pill, and 1 round white pill loose in the drawer of the medication cart. An interview was conducted with Nurse #6 on 10/05/16 at 12:56 PM who stated she could not identify the loose pills and she would dispose of them properly. An interview was conducted with the Director of Nursing (DON) on 10/06/17 at 12:01 PM. She stated that 3rd shift was responsible for completing the medication audits and the pharmacy had been there in August 2017 and gone through the medication carts as well. The DON stated she expected all medication to remains in its original packaging and not to be loose in the medication carts.	F 431		
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	F 520		11/3/17

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F 520	Continued From page 39 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 : (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 observation, staff interview, the facility's Quality Assessment and Assurance Committee (QA and A) failed to implement,	F 520	F520 1. Facility Administrator conducted a	

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F 520 Continued From page 40

monitor and revise as needed the action plan for the complaint survey dated 03/11/2017, in order to achieve and sustain compliance. The facility had a repeat deficiency for providing Activities of Daily Living (ADL) to dependent residents during the recertification and complaint investigation dated 10/06/2017. The continued failure of the facility during two complaint investigations shows a pattern of the facility's inability to sustain an effective Quality Assurance program.

The findings included:

This is cross referenced to F 312: Activities of Daily Living: Based on observations, record review, and staff interviews the facility failed to perform incontinent care (Resident #78) and failed to clean and trim dirty fingernails (Resident #65) for 2 of 5 dependent residents sampled for activities of daily living.

On 03/11/2017, the facility was cited for failure to provide assistance to a resident that required ADL assistance while using the bed pan.

An interview with the Administrator on 10/06/2017 at 2:21 PM revealed that the QA and A committee met weekly to continue to review both new areas of concerns as well as previous citations until the committee determined that the areas addressed were resolved. The Administrator stated that the facility had not discussed any concerns related to ADL care, specifically nail care and incontinent care. The Administrator revealed that the QA and A committee would begin addressing these concerns immediately in their weekly meetings.

F 520

QAPI meeting on 10/26/17 to discuss the recitation of tag F312.

2. All residents residing in the facility have the potential to be affected.

3. Facility Administrator and Director of Nursing reeducated the IDT and members of the QAPI committee regarding the importance of ongoing monitoring to ensure that all residents are receiving proper ADL as required per their care plan. This includes incontinence and fingernail care.

Licensed and Certified Nursing staff will be re-educated Director of Nursing and/or Assistant Director of Nursing on proper cleanliness and trimming of lengthy fingernails of dependent residents and ADL care by 11/3/17.

Unit Managers will conduct audits of 10 random dependent residents to ensure proper ADL care is being provided and lengthy fingernails are trimmed and cleaned. These audits will be conducted weekly for 12 weeks. Opportunities will be corrected as identified.

DDCS to monitor QAPI meetings monthly for 3 months by attending in person or via conference call and providing feedback for opportunities as identified.

4. The IDT will meet at least 2 x per month to conduct the facility□s QAPI meeting. The Medical Director will attend

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F 520	Continued From page 41	F 520	at least once per month. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiencies for F312, as well as, prevention of any new repeat deficiencies.	