STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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-	F 157		12/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2017

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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F 157	Continued From page 1 (A) A change in room or roommate assignment 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, observations and interviews the facility failed to inform the nurse of a resident with complaints of pain for 1 of 2 residents observed during incontinent care. (Resident #105) The findings included: Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Chronic Kidney Disease, Cerebrovascular Accident, Chronic constipation and a history of colon cancer. Review of the most recent Annual Minimum Data Set Assessment dated 9/22/17 identified Resident #105 as moderately impaired cognitively. Resident #105 had unclear speech, was usually understood by others and usually understood others. He did not have behaviors or reject care. He was totally dependent on two persons for bed mobility, transfers, toileting, hygiene, bathing and dressing. He had range of motion impairment to both the upper and lower extremities bilaterally. He was always incontinent of bowel and bladder. During an observation of incontinent care on	F 157	The process that led to this deficiency was nursing assistant (NA) #1 failed to notify the assigned hall nurse of resident # 105 pain. Resident # 105 was assessed by assigned hall nurse for pain with documentation in electronic medical record on 11/14/2017. Nurse #1 notified the attending physician of resident # 105 pain on 11/14/2017 with documentation in the electronic medical record. Nurse #1 notified the Resident Representative (RR) of resident # 105 pain on 11/14/207 with documentation in the electronic medical record. 100% audit of all nursing assistants was initiated by East and West Wing Treatment (TX) Nurses, Quality Improvement (QI) Nurse, and Registered Nurse (RN) Assistant Director of Nursing (ADON) on 11/21/2017 utilizing a Resident Care Audit Tool to ensure that nursing assistants are reporting a change in a resident□s condition to include any signs of symptoms of pain. The nursing	

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F 157	Continued From page 2 11/14/17 at 2:21 PM Nursing Assistant (NA) #1 was observed to clean the resident ' s perineal/inguinal area. The resident was observed to holler out in pain two times during the care when NA #1 wiped the area between his thigh and his penile area. NA #1 asked the resident if that hurt and he stated yes. Nursing Assistant #1 stated she had never had him complain of pain. When finishing care, Nursing Assistant #1 exited the room. During an interview with Nurse #1 on 11/14/17 at 2:45 PM she stated she was not aware that Resident #105 had complaints of pain but she would assess him. During an observation with Nurse #1 of Resident #105 on 11/14/17 at 2:47 PM she entered the resident ' s room to assess him. He was noted to have bowel sounds present in all four quadrants. He did complain of lower abdominal pain when Nurse #1 pushed on the area. During a follow up interview with Nurse #1 she stated she would give the resident medication to help with any discomfort and inform the oncoming nurse and notify the physician. Review of the Nursing Note dated 11/14/17 read Mylanta was given and the physician was notified as well as the responsible party. The note documented "waiting on response." Review of the Nursing Note dated 11/15/17 documented the Nurse Practitioner was in the building to assess Resident #105. During an interview with the Director of Nursing on 11/15/17 at 1:33 PM she stated it would be	F 157	assistant will be re-educated by the ADON and/or Director of Nursing (DON) during the audit for failure to report a change in condition to include pain during care, to be completed by 12/14/2017. 100% in-servicing was initiated on 11/22/2017 and will be completed by 12/14/2017 by the ADON with all Nursing assistants to include NA #1, regarding immediately reporting acute changes in condition to include pain. All newly hired nursing assistants will receive the in service on reporting acute changes in condition to include pain during orientation by the Staff Facilitator. 100% In-servicing was initiated on 11/22/2017 and will be completed by 12/14/2017 by the ADON with all licensed nurses to include the nursing supervisor regarding notification of the physician and Resident Representative for acute changes in condition to include pain with documentation of the notification in the clinical records. All newly hired Licensed Nurses will receive the in service regarding notification of the physician and Resident Representative for acute changes in condition to include pain with documentation of the notification in the clinical records during orientation by the Staff Facilitator. 10% of all residents will be audited during resident care by ADON, QI Nurse, and Treatment Nurses to ensure any change in condition is reported immediately to the nurse utilizing a Change in Resident	

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F 157	Continued From page 3 expected that the nursing assistants communicate with the nurses if there is anything different with the resident. We can't fix the problem if we don't know there's a problem.	F 157	Condition QI Audit tool weekly x 8 weeks and monthly x 1 month. The NA will be retrained by the ADON/DON during the audit if any areas of concerns are identified. The DON will review and initial the Change in Resident Condition QI Audit Tool weekly x 8 weeks and monthly x 1 month to ensure all areas of concerns have been addressed. The Director of Nursing will forward the results of the Resident Care Audit Tools to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of maintenance records the facility failed to clean the heating and air conditioning systems for the following rooms Room 606, 612, 615, 611, 603, 609, 600, 607, 613, 614 and 617 for 1 of 7 halls. The findings included. On 11/13/17 at 11:41 AM the heating and air	F 253	The process that led to this deficiency was the facility failed to clean the inside of the heating and air conditioning systems. The inside of the heating and air conditioning systems in room 606, 612, 615, 611, 603, 609, 600, 607, 613, 614 and 617 were cleaned on 11/20/2017 by the Maintenance Assistant.	12/14/17

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F 253	Continued From page 4 conditioning system in room 606 was observed with a large volume of gray dust on the inside grill panel. On 11/13/17 at 11:52 AM the heating and air conditioning system in room 612 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 8:33 AM the heating and air conditioning system in room 615 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 9:02 AM the heating and air conditioning system in room 611 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 9:05 AM the heating and air conditioning system in room 612 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 12:53 PM the heating and air conditioning system in room 603 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 12:54 PM the heating and air conditioning system in room 612 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 12:56 PM the heating and air conditioning system in room 615 was observed with a large volume of gray dust on the inside grill panel. On 11/14/17 at 12:57 PM the heating and air conditioning system in room 611 was observed with large volume of gray dust on the inside grill panel. On 11/15/17 at 8:56 AM the heating and air conditioning system in room 615 was observed with a large volume of gray dust on the inside grill panel.	F 253	100% observation of the inside of all heating and air conditioning systems was completed on 11/21/2017 by the Maintenance Director to ensure the inside of the heating and air systems were clean. Work orders were completed during the audit by the Administrator for notification to maintenance for any identified areas of concern. Maintenance addressed all areas of concerns from the audit by 12/14/2017. 100% in-service was initiated with housekeeping staff on 11/20/2017 by the Housekeeping Supervisor in regards to completing a work order when inside of heating and sir systems was noted to be dirty. 100% in-service was initiated with Maintenance Supervisor and Maintenance assistant on 11/17/2017 by the Administrator in regards to maintenance□s responsibilities of cleaning the inside of the heating and air system. A monthly schedule was provided to the Administrator on 11/17/2017 from the Maintenance Supervisor in regards to schedule for cleaning of the inside of the heating and air systems. 100% in-service was initiated on 11/27/2017 to be completed by 12/14/2017 by the Administrator and Staff Facilitor with all licensed nurses and nursing assistants to notify Maintenance services of any dirty heating and air systems noted during daily care to the residents by completing a work order slip.	

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F 253	Continued From page 5 On 11/15/17 at 8:57 AM the heating and air conditioning system in room 612 was observed with a large volume of gray dust on the inside grill panel. On 11/15/17 at 8:58 AM the heating and air conditioning system in room 611 was observed with a large volume of gray dust on the inside grill panel. On 11/15/17 at 9:00 AM the heating and air conditioning system in room 606 was observed with a large volume of gray dust on the inside grill panel. On 11/15/17 at 9:02 AM the heating and air conditioning system in room 603 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:41 AM the heating and air conditioning system in room 600 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:42 AM the heating and air conditioning system in room 606 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:43 AM the heating and air conditioning system in room 609 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:44 AM the heating and air conditioning system in room 607 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:45 AM the heating and air conditioning system in room 611 was observed with a large volume of gray dust on the inside grill panel. On 11/16/17 at 8:46 AM the heating and air conditioning system in room 613 was observed with a large volume of gray dust on the inside grill	F 253	All newly hired license nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation regarding notification of dirty heating and air systems noted during daily care of the residents by completing a work order slip and giving it to Maintenance. The Maintenance Director will monitor 10% of all resident rooms, to include rooms 606, 612, 615, 611, 603, 609, 600, 607, 613, 614 and 617 for cleanliness of the inside of the heating and air systems weekly x 8 weeks then monthly x 1 utilizing a Heating and Air Systems QI tool. The Maintenance Supervisor and/or Maintenance Assistant will address any identified areas of concern immediately during the audit. The Administrator will review and initial the Heating and Air Systems QI Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Heating and Air Systems QI tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Heating and Air Systems QI tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 253	Continued From page 6	F 253		

panel.
On 11/16/17 at 8:47 AM the heating and air conditioning system in room 612 was observed with a large volume of gray dust on the inside grill panel.
On 11/16/17 at 8:47 AM the heating and air conditioning system in room 615 was observed with a large volume of gray dust on the inside grill panel.
On 11/16/17 at 8:48 AM the heating and air conditioning system in room 614 was observed with a large volume of gray dust on the inside grill panel.
On 11/16/17 at 8:49 AM the heating and air conditioning system in room 617 was observed with a large volume of gray dust on the inside grill panel.
On 11/16/17 at 8:50 AM the heating and air conditioning system in room 609 was observed with a large volume of gray dust on the inside grill panel.
On 11/16/17 at 9:59 AM the housekeeping supervisor stated housekeeping staff were responsible to wipe down the front of the heating and air conditioning units and maintenance man cleaned the inside of the units.

On 11/16/17 at 10:09 AM the Maintenance Manager stated he had a cleaning schedule that he marked off after he had cleaned the heating and air condition unit in the room. He revealed he had just begun the cleaning schedule, and tried to clean two heating and air conditioning units per week.

On 11/16/17 at 10:15 AM the Director of Nursing stated she would get the Maintenance Manager and get the heating and air conditioning units taken care of.

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F 253	Continued From page 7 On 11/16/17 at 1:44 PM the Administrator stated she expected the heating and air conditioning units to be clean.	F 253		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		12/14/17

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F 278	Continued From page 8 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code diagnoses in the Minimum Data Set (MDS) Assessment under Section I for 2 of 5 sampled residents for unnecessary medications (Resident #169 and Resident #212) and the facility failed to code under Section M for Skin and Ulcer Treatments for 2 of 3 sampled residents(Resident #105 and Resident #136) with pressure ulcers. The findings included: 1. Resident #169 was originally admitted to the facility on 3/1/17 with diagnoses including Diabetes Mellitus Type 2, Hypertension, Chronic Obstructive Pulmonary Disease, Muscle Weakness, Difficulty Walking and Depression. Review of a Physician's order dated 3/1/17 noted Cymbalta 10mgs. for diagnosis of Depression. According to the Admission Minimum Data Set (MDS), five day, dated 3/8/17, Section I of the MDS was not coded for depression. Review of a Minimum Data Set (MDS), thirty day, dated 4/2/17, Section I of the MDS was not coded for depression. Resident #169's Care Plan dated 8/18/17 addressed use of psychotropic drugs with the potential for or characterized by side effects of cardiac, neuromuscular gastrointestinal systems due to diagnosis of anti-depressant.	F 278	The process that led to this deficiency was Minimum Data Set (MDS) Nurse failed to code diagnosis in section I for resident # 169 and resident # 212. MDS Nurse failed to code nutrition interventions in section M for resident # 136, and failed to code turning and repositioning under section M for resident # 105. Resident # 169, Minimum Data Set (MDS) assessment was modified by the MDS nurse on 11/27/2017 to reflect an accurate coding of the diagnosis of depression. Resident # 212, MDS assessment was modified by the MDS nurse on 11/16/2017 to reflect an accurate coding of the diagnosis of psychosis and depression. Resident # 136 MDS assessment was modified by the MDS Nurse on 11/16/2017 to reflect accurate coding of nutrition interventions. Resident # 105 MDS assessment was modified by the MDS nurse on 11/16/2017 to reflect accurate coding of turning and repositioning with oversite by the Director of Nursing (DON). A 100% audit of all residents most current MDS assessments will be reviewed by the Facility MDS Consultant to include Resident # 169, # 212, # 136 and # 105 to ensure all completed MDS assessments are coded accurately to include diagnosis of depression and	

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F 278	Continued From page 9 During an interview on 11/16/2017 at 11:31 AM, MDS Coordinator #1 revealed there was a problem with staffing and someone came in to try to help with the MDS. She stated she did not know why the MDS was not coded for depression. She revealed Resident #169 was receiving antidepressant at the time the MDS was completed. MDS Coordinator #1 added that Resident #169 had a diagnosis of depression since 3/1/17. She stated she did not complete Resident #169's MDS. During an interview on 11/16/2017 at 1:55 PM, the Administrator stated her expectation would be that the MDS should be coded correctly. 2. Resident # 212 was originally admitted to the facility on 9/15/17 and was readmitted on 10/6/17 with diagnoses including Non-Traumatic Intrachranial Hemorrhage, Hypertension, Dysphasia, GERD, Disorientation and Atypical Psychosis. According to the Admission Minimum Data Set (MDS), dated 9/22/17, Section I of the MDS was not coded for psychosis and depression .Review of an MDS, thirty day, dated 11/1/17, noted Section I was not coded for psychosis and depression. Review of a Nurse's note dated 9/21/17, read in part, "New order started today for Seroquel 50mgs. bid (twice daily)." A review of a Physician's telephone order dated 10/9/17 listed the diagnoses of Resident #212's medications, which read in part, "Prozac 20mg-depression, Risperdal 0.5mgs. atypical psychosis and Seroquel 25mgs. atypical	F 278	psychosis, and coding of prevention interventions. This audit will be completed by 12/14/2017 using a resident census. Modifications will be completed by the MDS nurse during the audit for any identified areas of concern with the oversight from the Director of Nursing (DON). An in-service was completed on 11/29/2017 for the MDS nurses by the Facility MDS Consultant regarding the proper coding of MDS assessments as indicated in the Resident Assessment Instrument (RAI) manual with emphasis that all MDS assessments are completed accurately and coded correctly to include a diagnosis of depression. All newly hired MDS nurses will be provided the in-service during orientation by the Staff Facilitator (SF) regarding the proper coding of MDS assessments as indicated in the RAI manual with emphasis that all MDS assessments are completed accurately and coded correctly to include a diagnosis of depression. 10% of all current residents completed MDS assessments to include Resident #169, # 212, # 136 and # 105 will be reviewed by the Quality Improvement (QI) nurse and Assistant Director of Nursing (ADON) to ensure accurate coding of the MDS assessments, including for a diagnosis of depression and psychosis, and prevention interventions. This audit will be conducted utilizing an MDS Accuracy QI Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of	

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F 278	Continued From page 10 psychosis." Review of Resident #212's Care Area Assessment Summary dated 9/22/17 revealed psychotropic medication was triggered and the recommendation was to care plan. The Care Area Assessment Summary noted Resident #212 had an order for Trazodone daily, Fluoxetine (Prozac) daily and Risperidone daily. The Care Area Assessment Summary (CAA)noted Resident #212 was admitted to the facility on 9/15/17 following a recent short stay in an acute care medical facility with a diagnosis history which included Delirium. A review of Resident # 212's care plan dated 10/4/17 addressed the use of psychotropic medication with potential for or characterized by side effects of cardiac, neuromuscular gastrointestinal systems due to diagnoses of delirium. The goal was to show minimal to no side effects of medications taken. The care plan also addressed the potential for delirium or actual acute confused state characterized by changes in consciousness and disorientation. During an interview on 11/15/2017 with MDS Coordinator #1 and MDS Coordinator #2 at 11:18 AM, MDS Coordinator #2 stated Resident #212 had diagnoses of alcohol abuse and disorientation. She revealed they looked at the discharge summary from the hospital and the nurse's determined what medications Resident #212 received and they received the doctor's orders. She stated if they needed an updated diagnosis for a particular medication the nurse would contact the doctor to get a diagnosis. She revealed the process was currently being corrected.	F 278	concern will be immediately addressed by the DON to include additional training and modifications to the MDS assessment as indicated. The DON will review and initial the MDS Accuracy QI Tool weekly for eight weeks and then monthly for one month for accuracy and to ensure all areas of concerns have been addressed. The DON will forward the results of the MDS Accuracy QI Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months to review the audit results of the MDS Accuracy QI Tool. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	

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During an interview on 11/15/2017 at 2:12 PM, the Director of Nursing (DON), stated the discharge summary from the hospital where Resident #212 was discharged contained admission medication. She stated some of the information was detailed and some of the information was very limited. She stated they get a diagnosis from the doctor and transcribe the medication on the MAR (Medication Administration Record). She revealed sometimes the follow-up took a week or two for the doctor to get back to them. She explained sometimes they had to call if they did not hear back from the doctor. The DON revealed this was something they were working on. She stated they have a doctor's group that would be in house for better response time for residents. She stated her expectation was to reach physician to get what they needed.

During an interview on 11/16/2017 at 1:51 PM the Administrator stated her expectation would be that the MDS would be coded correctly.

3. Resident #136 was admitted to the facility on 10/6/17 with diagnoses of anemia, dementia, quadriplegic cerebral palsy and a stage 2 pressure ulcer of the sacral region.

A review of the admission Medication Administration Record (MAR) dated 10/6/17 revealed Resident #136 was ordered Zinc, Vitamin C and a multiple vitamin for wound healing.

A review of the Wound Ulcer Flowsheet dated 10/10/17 revealed the resident was admitted with a stage 2 pressure ulcer to the coccyx area

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measuring 5 cm (centimeter) by 3 cm. The physician was notified on 10/10/17. Resident #136 was care planned to be turned and repositioned.

A review of his most recent admission Minimum Data Set (MDS) dated 10/13/17 revealed under section M1200 Skin and Ulcer Treatments, Nutrition interventions were not checked.

On 11/16/17 at 10:54 AM, the MDS Coordinator stated that for her to check Nutritional Interventions the order for Vitamin C, Zinc and a Multiple Vitamins should be on the admission physician ' s orders on the MAR. The MDS Coordinator stated that she did not think that the resident had any nutritional interventions on the MAR. The MDS Coordinator after checking the admission MAR stated that she should have coded under Skin and Ulcer Treatments, Nutritional interventions.

On 11/16/17 at 10:54 AM, the Administrator stated that the MDS Coordinator should have checked Nutrition Interventions under section M for skin and ulcer treatments because the resident was receiving Vitamin C, Zinc and a Multiple Vitamins on the Admission MAR.

4. Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Cerebrovascular Accident, Hemiplegia, Chronic Kidney Disease, Diabetes Mellitus and Contractures.

A review of the facility standing order pressure ulcer protocol dated 11/2012 titled, "Pressure Ulcer Prevention," read in part, "Rationale, Patients who have been assessed at

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moderate/high risk for pressure ulcer development may be placed on the following preventative program. This program includes nursing interventions that will begin after assessment and will continue until the patient is no longer at risk. Procedures 1. Turn and reposition patient and place on a turn schedule. 2. Pad bony prominences with pillows and or foam products. 2. Use positioning devices and protective devise as needed to protect susceptible areas from breakdown.

Review of the November 2017 Physician's Orders read "may use standing orders and approved facility protocols."

A review of the Wound Ulcer Flow sheet dated 9/6/17 revealed the resident acquired in house suspected deep tissue injuries to both the right and left heel on 9/6/17. The physician and responsible party were notified on 9/6/17. Resident #105 was care planned to be turned and repositioned and to receive skin prep treatment to the areas.

A review of his most recent annual Minimum Data Set (MDS) dated 9/22/17 revealed under section M1200 Skin and Ulcer Treatments, turning and repositioning and pressure ulcer care were not checked.

During an interview with the MDS Nurse #2 on 11/16/2017 at 12:07 PM she stated unless she knew there was a physician's order for turning and repositioning (T&P) and we saw the order on the Medication Administration Record then we do not know the resident was on a T&P program. It should have been checked that he was receiving pressure ulcer treatments.

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F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on standing order protocol, record review, observations and interviews the facility failed to implement care plan interventions by failing to turn and reposition residents with pressure ulcers for 2 of 3 residents (Resident #136 and #105), failing to implement bunny boots for 1 of 3 residents with pressure ulcers (Resident # 136) and failed to do weekly skin assessments 1 of 3 residents reviewed with pressure ulcers (Resident #105). The findings included: A review of the facility standing order pressure ulcer protocol dated 11/2012 titled, "Pressure Ulcer Prevention," read in part, "Rationale, Patients who have been assessed at moderate/high risk for pressure ulcer development may be placed on the following preventative program. This program includes nursing interventions that will begin after assessment and will continue until the patient is no longer at risk. Procedures 1. Turn and reposition patient and place on a turn schedule. 2. Pad bony prominences with pillows and or foam products. 2. Use positioning devices and	F 282	The process that led to this deficiency was Nursing Assistant (NA) # 2 failed to apply bunny boots and turn and reposition resident # 136 per the Resident Care Guide/ Care Plan. Resident # 136 will continue to receive bunny boots and turning/ repositioning per the Resident Care Guide. Resident # 105 will continue to be turned and repositioned per the Care Plan and wound assessments to be completed weekly. 100% return demonstration of all nursing assistants was initiated by the Registered Nurse (RN) Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) West Wing Treatment (TX) Nurse, East Wing TX Nurse and LPN Quality Improvement (QI) Nurse beginning on 11/28/2017 to assure the Nursing Assistants were performing turning and repositioning, and the application of bunny boots per the Resident Care Guide utilizing a Resident Care Audit Tool to be completed on 12/14/2017. Re-training	12/14/17

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F 282	Continued From page 15 protective devise as needed to protect susceptible areas from breakdown. Resident #136 was admitted to the facility on 10/6/17 with diagnoses of anemia, dementia, quadriplegic cerebral palsy and a stage 2 pressure ulcer of the sacral region. A review of the care guide dated 10/10/17 revealed the resident was to have bunny boots to his feet. A review of his most recent admission Minimum Data Set (MDS) dated 10/13/17 revealed Resident #136 was cognitively impaired with no behaviors. The resident was extensive assistance for transfers, dressing, for toilet use, personal hygiene and totally dependent on staff for bathing. A review of the Pressure Ulcer Care Area Assessment (CAA) dated 10/13/17 revealed the resident was at risk for developing additional pressure ulcers due to having a stage 2 pressure ulcer. A review of the admission assessment dated 10/6/17 revealed Resident #136 had a stage 2 pressure ulcer to his coccyx area. Interventions per the facility standing orders for pressure ulcer protocol was initiated. A review of the Norton scale for predicting risk of pressure ulcers revealed the resident was in fair physical condition, and alert, he was bed bound and immobile and incontinent of bowel and bladder and he received 5 or more mediations. He was assessed as having a high risk for developing a pressure ulcer.	F 282	was immediately conducted with nursing assistants during audit for any identified areas of concerns by 12/14/2017. On 11/21/2017, an audit of all current wounded residents was initiated by the TX Nurses to include assessing the current wounded residents for any changes. This audit was completed on 11/29/2017 with verification by the Facility Wound Consultant utilizing a Wound Assessment QI Tool to ensure all wounded residents had an assessment and that the physician was notified of worsening of wound as applicable. 100% in-service was initiated by the RN Director of Nursing (DON) on 11/14/2017 of nursing assistants in regards to turning and repositioning and application of bunny boots to include reading the resident care guide prior to all care to be completed by 12/14/2017. All newly hired nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to turning and repositioning and application of bunny boots to include reading the resident care guide prior to all care. On 11/29/2017, TX Nurses were in-serviced by the Facility Wound Consultant in regards to completion of weekly skin assessments on wounded residents. All residents with wounds will have a weekly wound assessment documented on the wound ulcer flow sheet in the electronic medical record. In the absence of the TX Nurse, the ADON and/or QI Nurse will complete the	

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F 282	Continued From page 16 On 11/14/17 at 2:06 PM Resident # 136 was observed without bunny boots. During an interview on 11/14/17 at 2:13 PM the resident's nursing assistant (NA#2) stated she had worked with Resident #136 and he was her usual assignment. NA#2 stated that the resident did not wear bunny boots and that the resident liked to stay on his back and did not like to be turned. NA#2 stated that the resident had not been turned during her shift. On 11/14/17 at 3:06 PM Resident #136 was observed lying on his back without bunny boots. On 11/15/17 at 7:59 AM Resident #136 observed on his back with the hob elevated 30 degrees and without his bunny boots. On 11/15/17 at 9:01 AM Resident #136 observed lying on his back. On 11/15/17 at 10:09 AM AM Resident #136 observed lying on his back without bunny boots On 11/15/17 at 10:13 AM the Treatment Nurse stated that Resident #136 was supposed to have bunny boots and was to be turned and repositioned with pillows. On 11/15/17 at 2:50 PM Resident #136 was observed lying on his back. On 11/16/17 at 11:15 AM during an interview with the NA#2 and the Administrator, NA #2 stated that the reason she did not know the resident was to have bunny boots and to be turned and repositioned was because she had not looked at the resident's care guide. The Administrator	F 282	assessment and the DON will validate. Observations of resident care to include application of bunny boots and turning/ repositioning to be completed on 10% of nursing assistants to include resident # 136 and # 105 by ADON, East and West Wing TX Nurses and QI Nurse to ensure the care guide is followed Resident Care audit tool weekly for 8 weeks and monthly X 1 month. All nursing assistants will be immediately retrained for any identified areas of concern by the ADON, East and West Wing TX Nurses and QI Nurse during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 8 weeks and monthly X 1 month for completion and to ensure all areas of concerns have been addressed. 10% of wounded residents weekly skin assessment will be audited by the ADON and QI Nurse to ensure all assessments are being completed weekly utilizing the Wound Assessment QI tool weekly X 8 weeks and monthly X 1 month. TX Nurses will be re-trained by the DON/ADON during the audit if any areas of concerns identified. The Director of Nursing will review and initial the Wound Assessment QI tool weekly X 8 weeks and monthly X 1 month to ensure to ensure all areas of concerns have been addressed. The Director of Nursing will forward the results of the Resident Care Audit Tools and Wound Assessment QI tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will	

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F 282	Continued From page 17 stated since the bunny boots were on the care guide the nursing assistant should have placed the residents bunny boots on. A review of the facility standing order pressure ulcer protocol dated 11/2012 titled, "Pressure Ulcer Prevention," read in part, "Rationale, Patients who have been assessed at moderate/high risk for pressure ulcer development may be placed on the following preventative program. This program includes nursing interventions that will begin after assessment and will continue until the patient is no longer at risk. Procedures 1. Turn and reposition patient and place on a turn schedule. 2. Pad bony prominences with pillows and or foam products. 2. Use positioning devices and protective devise as needed to protect susceptible areas from breakdown. Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Cerebrovascular Accident, Hemiplegia, Chronic Kidney Disease, Diabetes Mellitus, history of Pressure Ulcers and Contractures. Review of the most recent Annual Minimum Data Set assessment dated 9/22/17 identified Resident #105 as moderately impaired cognitively. He had unclear speech, was usually understood and usually understood others. He had no behaviors and did not resist care. He was totally dependent on two persons for bed mobility, transfers, toileting, hygiene, bathing and dressing. Resident	F 282	meet monthly x 3 months and review the Resident Care Audit Tools and Wound Assessment QI tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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#105 had range of motion impairment to both the upper and lower extremities bilaterally. He was always incontinent of his bowel and bladder.

Review of the Care Area Assessment dated 9/22/17 triggered related to Resident #105 being totally dependent for bed mobility, always incontinent of his bowel and bladder, at risk for pressure ulcer and had one or more unhealed pressure ulcers at a stage 2 or higher.

Review of the care plan dated 10/6/17 for actual skin breakdown or development of further pressure ulcers related to incontinence of the bowel and bladder and requiring total assistance with turning and positioning listed interventions, in part, to pad bony prominences with pillows or foam products, use positioning devices and protective/pressure reduction devices as needed to protect susceptible areas for breakdown.

Review of care plan dated 10/6/17 for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility. The goal read: will show positive healing with reduction in size/stage of the pressure ulcer by the next review. Interventions included, in part, staff to turn and reposition resident routinely, bunny boots to feet, follow facility protocol/regime for treating breaks in skin integrity/pressure ulcers for Stage II right heel and SDTI (suspected deep tissue injury) left heel, treatments as ordered by physician and weekly assessments of the wound/ulcer.

Review of the November 2017 signed Physician's Orders read "may use standing orders and approved facility protocols."

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Review of the medical record showed skin assessments for 9/13/17, 9/27/17 and 10/11/17 as not being completed.

During an observation on 11/13/17 at 1:00 PM Resident #105 was observed to be lying on his back with the head of the bed up. He was eating lunch unassisted.

During an observation on 11/13/17 at 3:40 PM Resident #105 was on his back. His heels were resting on the bed. He was wearing bunny boots. There were no pillows or wedges observed on the bed.

During an observation on 11/14/17 at 7:15 AM Resident #105 was observed sitting up in bed. The head of the bed was up. His juice was on the bedside table. His feet were resting on the bed. He was wearing bunny boots. There were no pillows or wedges observed on the bed.

During an observation on 11/14/17 at 8:10 AM Resident #105 was sitting up in bed waiting for his breakfast tray. There were no pillow or wedges observed on the bed.

During an observation on 11/14/17 at 9:05 AM Resident #105 was observed in bed, on his back. His heels were resting on the bed with bunny boots on.

During an observation on 11/14/17 at 10:33 AM Resident #105 was observed in bed on his back. His heels were resting on the bed with bunny boots on.

During an observation on 11/14/17 at 11:31 AM Resident #105 was observed in bed on his back.

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There were no pillows or wedges on bed for positioning.

During an observation on 11/14/17 at 1:00 PM Resident #105 was observed sitting up in bed. The head of the bed was up. He was observed feeding himself lunch.
During an observation on 11/14/17 at 1:46 PM in bed Resident #105 was observed in bed on his back. He had bunny boots on. There were no pillows or wedges for positions observed.

During an observation of incontinent care with Nursing Assistant #1 on 11/14/17 2:21PM Resident #105 was on his back. Resident #105 was observed to be unable to turn and reposition during care on his own. When placed on his left side by the Nursing Assistant he would flop back to his back immediately unable to use his right arm to hold on to the side rail due to weakness and a contracture. After completing incontinent care, Resident #105 was left on his back, bunny boots in place. There were no pillows or wedges for positioning observed. The Nursing Assistant did not ask the resident if he would like to be repositioned and did not reposition the resident.

During an observed on 11/14/17 at 3:41 PM Resident #105 was in bed on his back. There were no pillows or wedges seen in the room.

During an observation on 11/14/17 at 4:10 PM two 3pm-1pm Nursing Assistants used the mechanical lift to place Resident #105 into his wheelchair.

A dressing change on 11/15/17 at 9:39 AM with Treatment Nurse #1 and #2 was observed. Treatment Nurse #2 was observed to be assisting

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by holding Resident #105 ' s legs up for the dressing change. The right Stage II wound to the heel was dressed. Upon assessing the suspected deep tissue injury to the left heel, Treatment Nurse #1 stated the wound had opened up and she would now need to measure and stage the pressure wound. The measurements were 2 centimeters by 2 centimeters and it was a Stage II.

During an interview with Nursing Assistant #1 on 11/14/17 at 2:31 PM she stated she had been turning Resident #105 during the day. When she was made aware of hourly observations, NA #1 then stated the resident had refused to be turned and repositioned or get out of bed.

During an interview with Nurse #1 on 11/14/17 2:45 PM she stated that the resident will sometimes get up and sometimes after getting up he likes to go back to bed within a couple of hours. She stated the staff should be turning and repositioning him throughout the shift.

During an interview with Treatment Nurse #1 on 11/15/17 9:47 AM she stated positioning had attributed to his heels breaking down. His right heel was healing but now the left heel was a stage II. She stated skin assessments should have been done weekly but if she was off then the floor nurses were to do the assessments and sometimes those got skipped. She stated Resident #105 should be turned every two hours per our pressure ulcer protocol. She stated she would document in the progress notes if he refused to turn and reposition.

Review of progress note since the acquisition of two suspected deep tissue injuries to bilateral

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F 282	Continued From page 22 heels on 9/6/17 showed no documentation of refusals of care or turning and repositioning. During an interview with the corporate wound consultant on 11/16/17 at 11:49 AM she stated Resident #105 needed to be turned and repositioned and the weekly skin assessments should have been completed.	F 282		
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)	F 285		12/14/17

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F 285	Continued From page 23 (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.	F 285		

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F 285	Continued From page 24 (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 285	The process that led to this deficiency	

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F 285	Continued From page 25 facility failed to submit a Preadmission Screening and Resident Review (PASRR) after a significant change for 1 of 1 residents reviewed for PASRR. (Resident # 10). The findings included: Resident #10 was originally admitted to the facility on 5/11/15, with diagnoses including Sepsis, Acute Embolism and Thrombosis and Pressure Ulcer of Left Heel. Review of a PASRR Level II determination notification dated 9/30/15 revealed Resident #10 was approved for nursing home facility placement on 12/28/15. Review of a Significant Change Assessment Summary dated 5/15/17 revealed Resident #10 declined in the areas of transfers, walking and movement both on and off the unit, dressing, eating and toileting. Review of a Significant Change Assessment Summary dated 9/7/17, revealed Resident #10 increased in the areas of transfers, walking and movement both on and off the unit, dressing and toileting. During an interview on 11/15/2017 at 11:14 AM, MDS Coordinator #1 stated Resident #10 was on hospice for the first significant change on 5/15/17 and the second significant change on 9/7/17 was because Resident #10 was discharged from hospice on 8/28/17. During an interview on 11/15/17 at 2:43 PM, the facility Social Worker revealed a new application for PASRR Level II was not submitted when	F 285	was the Administrator and the West Wing Social Worker (SW) were unaware that a second application for a Preadmission Screening and Resident Review (PASRR) level II was required to be submitted after Resident #10 was discharged from hospice services. On 11/29/2017, Resident #10 PASRR level II application was submitted by the West Wing Social Worker (SW) to reflect the significant change to include the discharge from hospice services. On 11/29/2017 a 100% audit of all residents with a mental illness or intellectual disability for resident review for that past 6 months was conducted by the East Wing SW to include Resident #10. The audit will ensure that residents with a mental illness or intellectual disability for resident review with significant changes in mental or physical condition have a PASRR level II application submitted promptly by the facility after notification of the significant change. Any areas of deficient practice will be addressed immediately by the Administrator to include retraining of staff by the Administrator and submission of the PASRR level II application by SW. On 11/29/2017, the Administrator and the West and East Wing SW were in-serviced by the Facility Nurse Consultant regarding the requirement that an application for PASRR level II must be submitted for residents with a mental illness or intellectual disability for resident review	

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F 285	Continued From page 26 Resident #10 had a significant change. During an interview on 11/16/2017 at 1:58 PM, the Administrator revealed she did not realize another PASRR had to be submitted after Resident #10 was discharged from hospice and her expectation would be that it be completed the right way.	F 285	after a significant change has occurred to include a discharge from hospice services. Any newly hired Social Workers will be in-serviced during orientation by the Administrator regarding the requirement that an application for PASRR level II must be submitted for residents with a mental illness or intellectual disability for resident review after a significant change has occurred to include a discharge from hospice services. All residents with a mental illness or intellectual disability for resident review will be monitored utilizing a Significant Change for PASRR level II Residents Quality Improvement (QI) audit tool by the East Wing SW to include Resident #10 weekly for 8 weeks, then monthly for 1 month. The audit will ensure that residents with a mental illness or intellectual disability for resident review with significant changes in mental or physical condition have a PASRR level II application submitted promptly by the facility after notification of the significant change. Any areas of deficient practice will be addressed immediately by the Administrator to include retraining of staff by the Administrator and submission of the PASRR level II application by the East and West Wing SWs. The Administrator will review and initial the Significant Change for PASRR level II Residents QI audit tool for completion and accuracy weekly for 8 weeks, then monthly for 1 month.	

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F 285	Continued From page 27	F 285	The Administrator will review and present the results of the Significant Change for PASRR level II Residents QI audit tool to the Executive QI committee meeting monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include frequency of monitoring.	
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (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 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 facility standing orders for pressure ulcer protocol, record review, observations and staff interviews the facility failed to turn and reposition 2 of 3 residents with pressure ulcers (Residents #136 and #105), failed to implement bunny boots for 1 of 3 (Resident 136) residents	F 314	The process that led to this deficiency was Nursing Assistant (NA) failed to apply bunny boots for resident # 136, turn and reposition resident # 136 and # 105 per the Resident Care Guide/Care Plan.	12/14/17

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F 314	Continued From page 28 with pressure ulcers and failed to do weekly skin assessments for 1 of 3 residents (Resident #105) reviewed with pressure ulcers. The findings included: A review of the facility standing order pressure ulcer protocol dated 11/2012 titled, "Pressure Ulcer Prevention," read in part, "Rationale, Patients who have been assessed at moderate/high risk for pressure ulcer development may be placed on the following preventative program. This program includes nursing interventions that will begin after assessment and will continue until the patient is no longer at risk. Procedures 1. Turn and reposition patient and place on a turn schedule. 2. Pad bony prominences with pillows and or foam products. 2. Use positioning devices and protective devise as needed to protect susceptible areas from breakdown. 1. Resident #136 was admitted to the facility on 10/6/17 with diagnoses of anemia, dementia, quadriplegic cerebral palsy and a stage pressure ulcer of the sacral region. A review of the care guide dated 10/10/17 revealed the resident was to have bunny boots to his feet. A review of his most recent admission Minimum Data Set (MDS) dated 10/13/17 revealed Resident #136 was cognitively impaired with no behaviors. The resident was extensive assistance for transfers, dressing, for toilet use, personal hygiene and totally dependent on staff for bathing.	F 314	Resident # 136 will continue to receive bunny boots and turning/repositioning per the Resident Care Guide. Resident # 105 will continue to be turned and repositioned per the Care Plan and wound assessments to be completed weekly. On 11/16/2017, Resident # 136 had a Head to Toe Skin Assessment by the West Wing Treatment Nurse. No new changes in skin integrity were identified. On 11/16/2017, Resident # 105 had a Head to Toe Assessment was completed by the Charge Nurse. No new changes in skin integrity were identified. 100 % audit of all residents head to toe skin assessments for any changes in skin abnormalities was completed by charge nurse on 11/16/2017 with Physician and Resident Representative Notification of any identified changes. These assessments were documented utilizing a census sheet. 100% return demonstration of all nursing assistants was initiated by the Assistant Director of Nursing (ADON), Quality Improvement (QI) Nurse, West Wing Treatment (TX) Nurse and East Wing TX Nurse beginning on 11/18/2017 to assure the Nursing Assistants were performing turning and repositioning, and application of bunny boots per the Resident Care guide utilizing a Resident Care Audit Tool to be completed on 12/14/2017. Re-training was immediately conducted with nursing assistant during audit for any	

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F 314	Continued From page 29 A review of the Pressure Ulcer Care Area Assessment (CAA) dated 10/13/17 revealed the resident was at risk for developing additional pressure ulcers due to having a stage 2 pressure ulcer. A review of the admission assessment dated 10/6/17 revealed Resident #136 had a stage 2 pressure ulcer to his coccyx area. Interventions per the facility standing orders for pressure ulcer protocol was initiated. A review of the Norton Scale for predicting risk of pressure ulcers revealed the resident was assessed as having a high risk for developing a pressure ulcer. On 11/14/17 at 2:06 PM Resident # 136 was observed without bunny boots. During an interview on 11/14/17 at 2:13 PM the resident's nursing assistant (NA#2) stated she had worked with Resident #136 and he was her usual assignment. NA#2 stated that the resident did not wear bunny boots and that the resident liked to stay on his back and did not like to be turned. NA#2 stated that the resident had not been turned during her shift. On 11/14/17 at 3:06 PM Resident #136 was observed lying on his back without bunny boots. On 11/15/17 at 7:59 AM Resident #136 observed on his back and without his bunny boots. On 11/15/17 at 9:01 AM Resident #136 observed lying on his back. On 11/15/17 at 10:09 AM AM Resident #136 observed lying on his back without bunny boots	F 314	identified areas of concerns by 12/14/2017. On 11/27/2017, the TX Nurses initiated weekly wound assessments to be completed on 12/1/2017. On 11/29/2017, the Facility Wound Consultant utilized a Wound Assessment QI Tool to ensure all wounded residents had an assessment and that the physician was notified of worsening of wound as applicable. 100% audit of all residents noted to be at High Risk for Pressure Ulcers were initiated on 11/27/2017 by Minimum Data Set (MDS) Nurse to ensure all prevention interventions, bunny boots, pillows, wedges are in place for the prevention of pressure ulcers to be completed by 12/14/2017. 100% In-service was initiated on 11/27/2017 by the Director of Nursing (DON) with nursing assistants. Residents at high risk for developing pressure ulcers must be turned and repositioned routinely to include utilizing pillows and wedges as necessary. Residents at high risk for developing pressure ulcers will have all prevention interventions per the residents care plan to include bunny boots to be completed on 12/14/2017. 100% In-service was initiated on 11/27/2017 by the ADON with all licensed nurses in regards to: When the treatment nurse is off and a weekly wound assessment is due, the assessments will be completed by the hall nurse and documented in the electronic medical	

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F 314	Continued From page 30 On 11/15/17 at 10:13 AM the treatment nurse stated that Resident #136 was supposed to have on his bunny boots and was to be turned and repositioned with pillows. On 11/15/17 at 2:50 PM Resident #136 was observed lying on his back. On 11/16/17 at 11:15 AM during an interview with NA#2 and the Administrator present, NA#2 stated that the reason she did not know the resident was to have bunny boots and to be turned and repositioned was because she had not looked at the resident's care guide. The Administrator stated since the bunny boots were on the care guide the nursing assistant should have placed the residents bunny boots on. 2. Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Cerebrovascular Accident, Hemiplegia, Chronic Kidney Disease, Diabetes Mellitus, history of Pressure Ulcers and Contractures. Review of the most recent Annual Minimum Data Set assessment dated 9/22/17 identified Resident #105 as moderately impaired cognitively. He had unclear speech, was usually understood and usually understood others. He had no behaviors and did not resist care. He was totally dependent on two persons for bed mobility, transfers, toileting, hygiene, bathing and dressing. Resident #105 had range of motion impairment to both the upper and lower extremities bilaterally. He was always incontinent of his bowel and bladder. Review of the Care Area Assessment dated 9/22/17 triggered related to Resident #105 being	F 314	record by 12/14/2017. Observations of resident care to include application of bunny boots and turning/repositioning to be completed on 10% of nursing assistants to include resident # 136 and # 105 by the QI Nurse, TX Nurses, and the ADON to ensure the care guide is followed Resident Care audit tool weekly for 8 weeks and monthly X 1 month. All nursing assistants will be immediately retrained for any identified areas of concern by the Assistant Director of Nursing and/or the Director of Nursing during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 8 weeks and monthly X 1 month for completion and to ensure all areas of concerns have been addressed. 10% of wounded residents weekly skin assessment will be audited by the Quality Improvement Nurse to ensure all assessments are being completed weekly utilizing the Wound Assessment QI tool weekly X 8 weeks and monthly X 1 month. The treatment nurse will be re-trained by the Quality Improvement Nurse during the audit if any areas of concerns identified. The Director of Nursing will review and initial the Wound Assessment QI tool weekly X 8 weeks and monthly X 1 month to ensure to ensure all areas of concerns have been addressed. The Director of Nursing will forward the	

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F 314	Continued From page 31 totally dependent for bed mobility, always incontinent of his bowel and bladder, at risk for pressure ulcer and had one or more unhealed pressure ulcers at a stage 2 or higher. Review of the care plan dated 10/6/17 for actual skin breakdown or development of further pressure ulcers related to incontinence of the bowel and bladder and requiring total assistance with turning and positioning listed interventions, in part, to pad bony prominences with pillows or foam products, use positioning devices and protective/pressure reduction devices as needed to protect susceptible areas for breakdown. Review of care plan dated 10/6/17 for ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to: immobility. The goal read: will show positive healing with reduction in size/stage of the pressure ulcer by the next review. Interventions included, in part, staff to turn and reposition resident routinely, bunny boots to feet, follow facility protocol/regime for treating breaks in skin integrity/pressure ulcers for Stage II right heel and SDTI (suspected deep tissue injury) left heel, treatments as ordered by physician and weekly assessments of the wound/ulcer. Review of the medical record showed skin assessments for 9/13/17, 9/27/17 and 10/11/17 as not being completed. During an observation on 11/13/17 at 1:00 PM Resident #105 was observed to be lying on his back with the head of the bed up. He was eating lunch unassisted. During an observation on 11/13/17 at 3:40 PM	F 314	results of the Resident Care Audit Tools and Wound Assessment QI tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Resident Care Audit Tools and Wound Assessment QI tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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Resident #105 was on his back. His heels were resting on the bed. He was wearing bunny boots. There were no pillows or wedges observed on the bed.

During an observation on 11/14/17 at 7:15 AM Resident #105 was observed sitting up in bed. The head of the bed was up. His juice was on the bedside table. His feet were resting on the bed. He was wearing bunny boots. There were no pillows or wedges observed on the bed.

During an observation on 11/14/17 at 8:10 AM Resident #105 was sitting up in bed waiting for his breakfast tray. There were no pillow or wedges observed on the bed.

During an observation on 11/14/17 at 9:05 AM Resident #105 was observed in bed, on his back. His heels were resting on the bed with bunny boots on.

During an observation on 11/14/17 at 10:33 AM Resident #105 was observed in bed on his back. His heels were resting on the bed with bunny boots on.

During an observation on 11/14/17 at 11:31 AM Resident #105 was observed in bed on his back. There were no pillows or wedges on bed for positioning.

During an observation on 11/14/17 at 1:00 PM Resident #105 was observed sitting up in bed. The head of the bed was up. He was observed feeding himself lunch.
During an observation on 11/14/17 at 1:46 PM in bed Resident #105 was observed in bed on his back. He had bunny boots on. There were no

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pillows or wedges for positions observed.

During an observation of incontinent care with Nursing Assistant #1 on 11/14/17 2:21PM Resident #105 was on his back. Resident #105 was observed to be unable to turn and reposition during care on his own. When placed on his left side by the Nursing Assistant he would flop back to his back immediately unable to use his right arm to hold on to the side rail due to weakness and a contracture. After completing incontinent care, Resident #105 was left on his back, bunny boots in place. There were no pillows or wedges for positioning observed. The Nursing Assistant did not ask the resident if he would like to be repositioned and did not reposition the resident.

During an observed on 11/14/17 at 3:41 PM Resident #105 was in bed on his back. There were no pillows or wedges seen in the room.

During an observation on 11/14/17 at 4:10 PM two 3pm-1pm Nursing Assistants used the mechanical lift to place Resident #105 into his wheelchair.

A dressing change on 11/15/17 at 9:39 AM with Treatment Nurse #1 and #2 was observed. Treatment Nurse #2 was observed to be assisting by holding Resident #105 ' s legs up for the dressing change. The right Stage II wound to the heel was dressed. Upon assessing the suspected deep tissue injury to the left heel, Treatment Nurse #1 stated the wound had opened up and she would now need to measure and stage the pressure wound. The measurements were 2 centimeters by 2 centimeters and it was a Stage II.

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F 314	Continued From page 34 During an interview with Nursing Assistant #1 on 11/14/17 at 2:31 PM she stated she had been turning Resident #105 during the day. When she was made aware of hourly observations, NA #1 then stated the resident had refused to be turned and repositioned or get out of bed. During an interview with Nurse #1 on 11/14/17 2:45 PM she stated that the resident will sometimes get up and sometimes after getting up he likes to go back to bed within a couple of hours. She stated the staff should be turning and repositioning him throughout the shift. During an interview with Treatment Nurse #1 on 11/15/17 9:47 AM she stated positioning had attributed to his heels breaking down. His right heel was healing but now the left heel was a stage II. She stated skin assessments should have been done weekly but if she was off then the floor nurses were to do the assessments and sometimes those got skipped. She stated Resident #105 should be turned every two hours per our pressure ulcer protocol. She stated she would document in the progress notes if he refused to turn and reposition. Review of progress note since the acquisition of two suspected deep tissue injuries to bilateral heels on 9/6/17 showed no documentation of refusals of care or turning and repositioning. During an interview with the corporate wound consultant on 11/16/17 at 11:49 AM she stated Resident #105 needed to be turned and repositioned and the weekly skin assessments should have been completed.	F 314		
F 318	INCREASE/PREVENT DECREASE IN RANGE	F 318		12/14/17

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F 318 SS=E	Continued From page 35 OF MOTION CFR(s): 483.25(c)(2)(3) (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 practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure a splint was applied and passive range of motion exercises were provided for one of one resident (Resident #105) reviewed for contractures. The findings included: Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Dementia, Diabetes Mellitus, Cerebrovascular Accident and Hemiplegia. Review of the most recent Annual Minimum Data Set Assessment dated 9/22/17 identified Resident #105 as moderately impaired cognitively. Resident #105 had unclear speech, was usually understood by others and usually understood others. He did not have behaviors or reject care. He was totally dependent on two persons for bed mobility, transfers, toileting, hygiene, bathing and dressing. He had range of motion impairment to	F 318	The process that led to this deficiency was the Restorative/Quality Improvement (QI) Nurse overlooked Resident #105 restorative referral from therapy resulting in Resident #105 not being added to the restorative caseload as indicated by not receiving splint applications and passive range of motion (PROM) exercises for contractures. On 11/14/2017, Resident #105 was referred to therapy by the Restorative/QI Nurse due to worsening contracture as a result of splint not being applied as recommended. On 11/14/2017, a 100% audit of all residents to include Resident #105 was completed by QI Nurse and TX Nurse to ensure no resident had a new or worsening contracture. Resident #105 was referred to therapy by the	

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F 318	Continued From page 36 both the upper and lower extremities bilaterally. He was always incontinent of bowel and bladder. Review of the Care Area Assessment dated 9/22/17 triggered in the area of Activities of Daily Living related to Resident #105 requiring total assistance for bed mobility, transferring, toileting, bathing, dressing and hygiene. Problems Resident #105 would be at risk for included: pressure ulcers, contractures and incontinent. Review of the Care Plan, revised date of 10/6/17, had a focus of required assistance/potential to restore or maintain maximum function of self-sufficiency for mobility. At risk for further contracture to left upper extremity. The goal was contractures to the left upper extremity would not worsen as evidenced by no pain or discomfort by the next review. There were no interventions listed. Review of the Care Plan, revised dated of 10/6/17, had a focus of required assistance/potential to restore or maintain maximum function of self-sufficiency for mobility. At risk limitation range of motion in lower extremities. The goal was to maintain or increase mobility function/strength/flexibility (range of motion) to bilateral lower extremities as evidenced by no pain, discomfort or contracture formation thru next review. There were no interventions listed. Review of the Rehab Communications to Nursing, dated 8/9/17, documented Resident #105 was being discharged from therapy on 8/14/17 and was to begin restorative services on 8/15/17. Resident #105 was to receive bilateral upper extremity passive range of motion	F 318	Restorative/QI Nurse due to worsening contracture. There were no other identified areas of concern during the audit. On 11/14/17, a 100% audit was initiated by the Director of Nursing (DON) of all residents on the current restorative caseload to include Resident #105 to be completed by 12/14/2017 to ensure all residents on the restorative caseload were participating to include splint applications and/or PROM exercises as indicated on the care plan. All residents on the current restorative caseload were referred to therapy for evaluation to ensure the current restorative treatment program was appropriate. Residents will be added to the restorative caseload as recommended by therapy by the DON. On 11/14/2017, an in-service for the Restorative/QI Nurse was presented by the DON regarding the restorative responsibilities to include monitoring of therapy communication to nurses, placing residents on restorative as indicated by therapy, and monitoring the residents progress for possible referrals back to therapy. Any newly hired Restorative/QI nurses will be in-serviced by the SF during orientation regarding the restorative responsibilities to include monitoring of therapy communication to nurses, placing residents on restorative as indicated by therapy, and monitoring the residents progress for possible referrals back to therapy.	

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F 318	Continued From page 37 exercises consisting of two (2) set of ten (10) repetitions of shoulder flex/extension, shoulder abduction/adduction, elbow flexion/extension, wrist flexion/extension and finger flexion/extension and he was to have a splint applied to the left hand, palm guard daily up to four (4) hours a day. The short term goal was to maintain joint mobility to decrease risk of further contractures. The frequency of the program was 7 times per week. Observations were made on 11/13/17 at 1:00 PM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor. Observations were made on 11/13/17 at 3:40 PM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor. Observations were made on 11/14/17 at 7:15 AM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor. Observations were made on 11/14/17 at 8:10 AM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor. Observations were made on 11/14/17 at 9:05 AM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place.	F 318	All restorative referrals will be reviewed by the Assistant Director of Nursing (ADON) weekly for twelve weeks and then ongoing as restorative referrals are submitted by therapy to ensure all residents with referrals for the restorative caseload are participating in the restorative caseload to include splint applications and/ or PROM exercises utilizing a Restorative Referral QI Audit Tool. The DON will review and initial the Restorative Referral QI Audit tool for completion and accuracy weekly for twelve weeks. The Administrator will review and present the findings of the Restorative Referral QI Audit tools to the Executive Quality Improvement (QI) committee meeting monthly for three months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include frequency of monitoring.	

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There was no fall mat observed on the floor.

Observations were made on 11/14/17 at 10:33 AM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor.

Observations were made on 11/14/17 at 11:31 AM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor.

Observations were made on 11/14/17 at 1:00 PM. Resident #105 was lying on his back in bed with the head of the bed up. His lunch tray was observed on the bedside table. Resident #105 was feeding himself with his right hand scooping his food onto the utensil. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor.

Observations were made on 11/14/17 at 1:46 PM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor.

Observations on 11/14/17 at 2:21 PM during incontinent care, Resident #105 was noted to have contractures of the right and left wrist. He was observed to unable to hold onto the side rail when rolled to either side. He was not observed to be wearing any splint. The hand splint was observed to be sitting next to the sink. Resident #105 ' s legs, bilaterally, were resting on the bed.

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He had bunny boots on both the right and left foot. He was unable to move his legs to assist with bed mobility during turning and repositioning for incontinent care.

Observation were made on 11/14/2017 at 3:41 PM. Resident #105 was lying on his back in bed. His left and right wrist were observed with contractures. There was no splint in place. There was no fall mat observed on the floor.

Observations were made on 11/15/2017 8:22 AM during the breakfast meal. Resident #105 was sitting in bed with the head of the bed up feeding himself by scooping his food onto the utensil. He was observed to have contractures to the right and left wrist area. There was no splint in place. There was no fall mat on the floor.
Observations were made on 11/15/2017 at 9:39 AM during a pressure ulcer treatment. Resident #105 was unable to lift his legs. NA #2 assisted the Treatment Nurse in holding the resident ' s legs up while the dressings to both heels was done.

Observations were mad on 11/15/17 at 3:30 PM. Resident #105 was observed up, dressed, bunny boots on, sitting at the nursing station. He was observed to be wearing a hand splint to the left hand.

During an interview with Nurse #1 on 11/13/2017 at 2:10 PM she stated the resident did have contractures of his wrist. She did not know if he wore a splint.

During an interview with NA #3 on 11/14/2017 at 4:13 PM she stated she's never seen the resident wear a splint on his hands.

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During a follow up interview with Nurse #1 on 11/14/17 at 3:23 PM she stated it was hit or miss with him and wearing his splint.
During an interview with the Restorative Nurse on 11/15/2017 at 8:27 AM she stated he has not been on the restorative case load this year. She then reviewed the computer notes and stated he had an order for restorative and therapy was discontinued due to refusal. She stated she would look for the documentation.

During a follow-up interview with the Restorative Nurse on 11/15/17 at 9:05 AM she stated he did have a restorative referral in August 2017 and it was over-looked. She stated yesterday she asked OT/PT to reevaluate the resident.

During an interview with the Occupational Therapist on 11/16/17 at 9:15 AM he stated the resident had always had a contracture. When he was transferred to restorative in August 2017 he was supposed to be wearing a Palm guard. He stated he did not know what happened to that splint as it was not in his room yesterday when he evaluated him. There was an older splint in the room that he used prior to the Palm splint but that splint would not fit because his muscle tone had now gotten to the point where his hand was clenched. He stated the resident ' s pinky finger and ring ringer on the left hand had left indentations in his hand. He further stated Resident #105 ' s muscle tone had gotten to a point where his old splint wouldn ' t fit. He stated the goal now would be to use the Palmer splint in hopes it would stretch out the muscles again. He stated splinting had to be consistent for it to be effective.
During an interview with the Minimum Data Set

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F 318	Continued From page 41 Coordinator #1 on 11/16/2017 at 10:19 AM she stated restorative die the care plan for mobility and splints and range of motion. She stated it appeared, in the computer, that restorative was cancelled in July and therefore there were no interventions. During a follow up interview with the restorative nurse on 11/16/2017 at 10:24 AM she stated because restorative was missed and not picked back up in August the care plan did not get done. She stated she would assume therapy would not be doing passive range of motion with the resident since they reassessed him and added him to their schedule. She stated she had not been doing any type of passive range of motion to his lower extremities. During an interview with the Nurse Practitioner on 11/16/17 at 10:00 AM she stated she would have expected for the splint to be applied to prevent the contracture from becoming worse. If it was not applied I should have been made aware and the reason it was not applied.	F 318		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to be free of a medication error rate greater than 5% as	F 332	The process that led to this deficiency was the licensed nurse failed to follow the Medication Administration Record (MAR)	12/14/17

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F 332	Continued From page 42 evidenced by 2 medication errors out of 25 opportunities resulting in a medication error rate of 8% for 1 of 3 residents (Resident #23) observed during medication pass. The findings included: Resident was admitted to the facility on 12/28/15 and re-admitted on 3/25/16 with diagnoses including Diabetes Mellitus. 1) On 11/14/17 at 7:22 AM, Nurse #1 was observed preparing medication for administration to Resident #23. The medications pulled for administration included Toujeo (used for Diabetes) 14 units. The nurse was observed as she administered the Toujeo to Resident #23. Review of the Physician ' s orders for November 2017 and signed by the physician read Toujeo 14 units subcutaneously every morning. The hour of administration listed 9AM. Review of the Medication Administration Record documented an order for Toujeo 14 units SQ at 9AM. During an interview with Nurse #1 on 11/14/17 at 8:12 AM she stated that Resident #23 ' s sugars typically run high so we give all the medications at this time. During an interview with Consultant Pharmacist on 11/14/17 at 3:45 PM she stated that if the Toujeo was ordered daily by the physician to be given at 9AM then medication could be given one hour prior to 9AM or up to one hour after 9AM. During an interview with the Director of Nursing on 11/15/2017 10:20 AM she stated that she would expect a medication that is ordered for	F 332	for administering insulin in the correct time frame and administering insulin with a meal. Nurse #1 no longer works at facility. Resident #23 received insulin at the correct time per the MAR on 11/30/2017 by the assigned hall nurse with supervision by the Director of Nursing (DON). Resident #23 received insulin with a meal per the MAR on 11/30/2017 by the assigned hall nurse with supervision by the DON. 100% of licensed nurses were observed administering insulin at the correct time and if ordered with a meal to ensure medication error rate is less than 5%, physician orders are being followed to include orders for insulin administered timely and insulin given with a meal initiated on 11/29/2017 by the Facility Pharmacy Consultant to be completed by 12/14/2017 by the Assistant Director of Nursing (ADON), Quality Improvement (QI) Nurse, and Treatment (TX) Nurses utilizing a Medication Pass Audit Tool. The DON and/or ADON will immediately retrain the licensed nurse for any identified areas of concern during the audit. 100% in-service was initiated on 11/14/2017 by the DON with all licensed nurses regarding the 6 rights of medication administration, following physician orders for insulin injections to include Take with meals- must be given with meals and medications must be	

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F 332	Continued From page 43 9am to be given at 9am or within the parameters of an hour before or an hour after. 2) On 11/14/17 at 7:22 AM, Nurse #1 was observed preparing medication for administration to Resident #23. The medications pulled administration included Humalog (used for Diabetes) 10 units. Review of the Physician ' s orders for November 2017 and signed by the physician read Humalog not to be given over 30 minutes prior to meal. Review of the Physician ' s orders dated 11/1/17 for Humalog injection 100/ml (milliliters) give 10 units SQ (subcutaneously) TID (three times daily) with meals. The hour of administration listed 7:30AM. During an observation on 11/14/17 at 8:09 AM the breakfast tray for Resident #23 was delivered to her room and set up by the nursing assistant. During an interview with Nurse #1 on 11/14/17 at 8:12 AM she stated that Resident #23 ' s sugars typically run high so we give all the medications at this time. During an interview with the Consultant Pharmacist on 11/14/17 at 3:45 PM she stated that when giving the Humalog insulin the resident needed to eat within 15 minutes, it is a fast acting insulin. She stated that when an order reads give with meals this means it should be given 15 minutes prior to a meal, during a meal or when the resident puts their fork down. It needs to be given with food. During an interview with the Director of Nursing	F 332	administered within 1 hour before or after the time indicated on the MAR to be completed by 12/14/2017. All newly hired licensed nurses will be in-serviced by the Staff Facilitator (SF) during orientation regarding the six rights of medication administration following physician orders for insulin injections to include Take with meals- must be given with meals and medications must be administered within 1 hour before or after the time indicated on the MAR. The Medication Pass Audit Tool will be utilized by the ADON, QI Nurse, and TX Nurses with observation of 10% of licensed nurses to ensure medication error rate is less than 5%, licensed nurses are following physician orders during medication administration to include orders for insulin administered timely and insulin given with a meal weekly x 8 weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by the DON/ADON. The DON will review and initial the Medication Pass Audit Tool for completion and appropriate medication administration to residents to include resident #23 for completion and to ensure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The Director of Nursing will forward the results of the Medication Pass Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee	

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F 332	Continued From page 44 on 11/15/2017 10:20 AM she stated that she would expect a medication to be given as ordered and that Humalog insulin should be given with meals.	F 332	will meet monthly x 3 months and review the Medication Pass Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 372 SS=F	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, policy review and staff interviews the facility failed to maintain the area surrounding the dumpster free of debris for 2 of 2 dumpsters observed. The findings included: Review of the Housekeeping Manual (revised 12/98) under Walks, Driveways, Dumpster and Traffic areas reads as: "Dumpster area should be clean and free of debris, follow local sanitation rules for additional requirements." An observation of the dumpster area on 11/14/17 at 1:42 PM five blue disposable gloves were observed in front and to the left side of dumpster #1 located on the left. Four white disposable white gloves were observed in front of dumpster # 2 located to the right. On 11/15/17 at 7:40 AM three blue disposable gloves were observed in front and to the left side of dumpster # 1. Four white disposable white gloves were observed in front of dumpster # 2. On 11/16/17 at 9:42 AM three blue disposable	F 372	The process that led to this deficiency was that staff failed to ensure all debris was removed from the dumpster area. On 11/16/2017, the area surrounding the dumpster was cleaned to be free of debris by the Housekeeping Supervisor. 100% Observation of the dumpster area was completed on 11/16/2017 by the Housekeeping Supervisor utilizing an audit tool of the area surrounding the dumpster to ensure it is free of debris. It was noted that the area surrounding the dumpster was free of debris on 11/16/2017. On 11/16/2017, 100% in-service was initiated for all staff members to include Housekeeping, Dietary and Maintenance Department to ensure no debris is left in the surrounding areas of the dumpster to be completed by 12/14/2017 by the Housekeeping and Dietary Supervisor. The area surrounding the dumpster will be	12/14/17

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F 372	Continued From page 45 gloves were observed in front and to the left side of dumpster #1 and one white disposable glove was observed behind the grease dumpster. Two white disposable white gloves were observed behind dumpster # 2 next to building. On 11/16/17 at 9:52 AM the Housekeeping Supervisor stated once housekeeping staff put the trash into the dumpster she expected them to pick up the area surrounding the dumpsters. On 11/16/17 at 10:06 AM the Dietary Manager stated all staff were trained to pick up around the dumpster area. She would expect all facility staff to pick up around the dumpster area daily, as all staff were responsible. On 11/16/17 at 2:49 PM the Administrator stated she expected staff to keep the dumpster area clean.	F 372	audited 5 times per week for 4 weeks, then weekly for 8 weeks by the Housekeeping and/or Dietary Supervisor utilizing a Dumpster Area Quality Improvement (QI) tool. The Housekeeping and/or Dietary Supervisor will address any identified areas of concern immediately during the audit. The Administrator will review and initial the Dumpster Area QI Audit tool 5 x a week for 1 month then weekly x 2 months for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the dumpster audit to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the dumpster QI Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 441		12/14/17

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F 441	Continued From page 46	F 441		

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

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

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

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

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

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

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

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed

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F 441	Continued From page 47 by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to remove visibly soiled gloves and wash hands after providing incontinence care and before continuing care for 1 of 2 residents observed (Resident #105). The findings included: Review of the facility Hand Washing policy, dated 9/2014, read, in part, Personnel should wash their hands: when indicated between tasks and procedures to prevent cross contamination of different body sites and when hands are visibly and obviously soiled. Resident #105 was admitted to the facility on 11/16/15 and re-admitted on 7/17/17 with diagnoses including Diabetes Mellitus, Cerebrovascular Accident and Hemiplegia. During an observation of incontinent care on 11/14/17 at 2:21 PM Nursing Assistant (NA) #1 entered the room and washed her hands. She was observed to don gloves. Resident #105 was	F 441	The process that led to this deficiency was Nursing Assistant (NA) failed to remove visibly soiled gloves and wash hands after providing incontinent care. Nursing Assistant (NA) #1 was in-serviced on proper hand hygiene per the facility policy on handwashing and removing visibly soiled gloves on 11/15/2017 by the Director of Nursing (DON). A return demonstration was given by Nursing Assistant #1 on proper hand hygiene to include removing gloves when visibly soiled and washing hands before and after wearing gloves by the West Wing Treatment (TX) Nurse on 11/21/2017 after receiving the re-education with no identified areas of concerns. A 100% of all nursing assistants (NA) to include NA #1 will be observed by the DON, Assistant Director of Nursing (ADON), Quality Improvement (QI) Nurse, and West and East Wing TX Nurses	

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F 441	Continued From page 48 lying on his back. NA #1 unfastened the brief and was observed to clean the front perineal area. NA #1 then rolled Resident #105 to his left side. Stool was observed. NA #1 used wipes to remove the stool. The resident was noted to keep falling backwards onto his back as he was unable to hold himself on his side. There was observed stool on NA #1 ' s right glove. Upon completing perineal care, NA #1 rolled Resident #105 back to his back and then removed his shirt which was covered with food. She placed a hospital gown on the resident and then was observed to use a new, clean wipe and clean his right hand, which he had used for eating lunch. The NA #1 then cleaned the left hand. She then took a clean sheet and covered the resident and then placed a clean blanket on top of the sheet. NA #1 then removed the glove from her left hand and picked up the soiled linen bag and trash bag with her right, gloved hand and used her left hand to open the door and place the soiled bags into the hampers outside of the room. NA #1 then returned to the room, removed the right hand glove and washed her hands. During an interview with NA #1 on 11/14/17 at 2:31 PM she stated she would not have changed gloves between incontinent care and dressing and cleaning the resident ' s hands because she did not see stool on the glove. During an interview with the Director of Nursing on 11/15/17 at 10:48 AM she stated she would expect the Nursing Assistant to remove her soiled gloves and wash her hands prior to dressing the resident and washing his hands and placing new linen on the bed.	F 441	performing proper hand hygiene to include removing gloves when visibly soiled and washing hands before and after wearing gloves to ensure the facility handwashing policy is being followed utilizing a Resident Care Audit Tool to be completed by 12/14/2017. The nursing assistant will be immediately retrained during the observation by the DON, ADON, QI Nurse, and West and East Wing TX Nurses for any identified areas of concern. 100% in-service was initiated on 11/15/2017 by the DON with all nursing assistants to include NA #1 regarding the handwashing policy to include removing gloves when visibly soiled and washing hands before and after wearing gloves by the Assistant Director of Nursing (ADON) to be completed by 12/14/2017. All newly hired nursing assistants will receive education during orientation by the Staff Facilitator regarding the handwashing policy to include removing gloves when visibly soiled and washing hands before and after wearing gloves. 10% of all nursing assistants to include Nursing Assistant #1 will be observed by the DON, ADON, QI Nurse, and West and East Wing TX Nurses to ensure proper hand hygiene is being performed to include removing gloves when visibly soiled and washing hands before and after wearing gloves utilizing a Resident Care Audit tool weekly x 8 weeks then monthly x 1 month. The DON, ADON, QI Nurse and West and East Wing TX	

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F 441	Continued From page 49	F 441	Nurses will immediately retrain the nursing assistant for any identified concerns during the audit. The Director of Nursing will review and initial the results of the Resident Care Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Resident Care Audit tools to the Executive Committee monthly X 3 months. The Executive committee will meet monthly and review the Resident Care Audit tools and address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 460 SS=D	BEDROOMS ASSURE FULL VISUAL PRIVACY CFR(s): 483.90(e)(1)(iv)-(v) (e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; (e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide full visual privacy for one of one (Resident #93) sampled resident. The findings included:	F 460	The process that led to the deficiency was staff failed to make housekeeping staff aware that privacy curtain would not provide full visual privacy for resident #93. The privacy curtain for resident #93 was replaced on 11/15/2017 by the	12/14/17

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F 460	Continued From page 50 Resident #93 was admitted to the facility on 8/7/17 and readmitted on 10/13/17 with diagnoses to include Cancer, Parkinson ' s disease and dementia with behaviors. Review of Resident #93's most recent quarterly MDS (Minimum Data Set) dated 01/20/2017, revealed the resident had short and long-term memory problems and was severely impaired in cognitive skills for daily decision making. The assessment also indicated that Resident #93 required extensive assistance with his activities of daily living to include incontinence care. On 11/15/17 at 2:03 PM nursing assistant (NA #1) with NA#5 were observed raising Resident #93 ' s bed to provide incontinence care. Resident 93 ' s roommate was observed finishing his lunch and was asked if he minded if they pulled the privacy curtain. The privacy curtain between the resident's beds was pulled and then the privacy curtain on the roommate's side of the room was pulled at the foot of his bed to enclose the roommate. The privacy curtain between the two residents was observed with about an 18- inches gap between the residents' beds at the head of the bed and at the bottom of the bed another 12-inches gap. The privacy curtain between the residents did not reach the foot of Resident #93 ' s bed exposing the entire foot of the bed. The resident's roommate stated he wanted to watch TV and opened the privacy curtain on his side of the room. When the roommate opened the privacy curtain Resident #93 was observed receiving incontinence care. On 11/15/17 at 2:17 PM, NA#1 stated that she had not noticed that the privacy curtain did not reach around the resident to provide privacy.	F 460	Housekeeping Supervisor to provide full visual privacy. 100% observation of all other privacy curtains was completed on 11/15/2017 by the Housekeeping Supervisor utilizing a resident census to ensure full visual privacy. Any identified areas of concern were corrected during the audit by the Housekeeping Supervisor and completed on 11/15/2017. 100% in-service was initiated on 11/30/2017 by the Administrator with the Housekeeping Manager and Housekeeping staff in regards to checking privacy curtains daily during the daily room cleaning and to replace if privacy curtain does not provide full visual privacy to be completed by 12/14/2017. A monthly schedule was provided to the Administrator on 11/17/2017 from the Housekeeping Supervisor. 100% in-service was initiated on 11/15/2017 by the Director of Nursing (DON) with all licensed nurses and nursing assistants (NA) to include NA #1 and NA #5 in regards to when providing care the privacy curtain must provide full visual privacy. Licensed nurses and/or nursing assistants are to notify Housekeeping services of any privacy curtains noted not providing full visual privacy when providing care to the residents by completing a work order slip. All newly hired licensed nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation	

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F 460	Continued From page 51 NA#5 stated that she had noticed that the curtain did not completely go around the resident, but when the Resident #93 ' s roommate opened the privacy curtain she did cover the resident with a blanket. On 11/16/17 at 10:30 AM the Housekeeping Manager stated that the last time Resident #93's room had been deep cleaned was on 11/6/17 when his roommate was admitted. She stated staff had taken the privacy curtains down and cleaned them and had not noticed that when they put the curtains back up they did not reach from end to end. The privacy curtain should have reached all the way around the resident. On 11/16/17at 10:32 AM the Administrator stated that the privacy curtain should have reached completely around the resident that was being cared for to provide full visual privacy.	F 460	regarding when providing care the privacy curtain must provide full visual privacy. The licensed nurse and/or nursing assistant are to notify Housekeeping services of any privacy curtains noted not providing full visual privacy when providing care to the residents by completing a work order slip. The Housekeeping Supervisor will monitor 100% of all resident rooms with privacy curtains, to include resident #93 room, to ensure that all privacy curtains provide full visual privacy weekly x 8 weeks then monthly x 1 utilizing a Housekeeping Privacy Curtain Quality Improvement (QI) tool. The Housekeeping Supervisor will immediately address any identified areas of concern during the audit. The Administrator will review the Housekeeping Privacy Curtain QI Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Housekeeping Privacy Curtain QI tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Housekeeping Privacy Curtain QI tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		12/14/17

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F 520	Continued From page 52 CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (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 : (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	F 520		

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F 520	Continued From page 53 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification survey of 12/1/16. This was for two deficiencies which were recited during the recertification survey of 11/16/17 in Resident Assessment at F-278 and F-282. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F-278-Based on medical record review and staff interviews, the facility failed to accurately code diagnoses in the Minimum Data Set (MDS) Assessment under Section I for 2 of 5 sampled residents for unnecessary medications (Resident #169 and #212) and the facility failed to accurately code under Section M for Skin and Ulcer Treatments for 2 of 3 sampled residents (Resident #105 and #136) with pressure ulcers. F-278 was originally cited on 12/1/16 for failing to accurately assess 4 of 27 sampled residents (Resident #61, Resident #151, Resident #29 and Resident #102) for active diagnoses under Section I of the Minimum Data Set Assessment. F-282-Based on record review, observation, and	F 520	The process that led to this deficiency was Minimum Data Set Nurse (MDS) Nurse failed to code diagnosis in section I for resident #169 and resident #212. MDS Nurse failed to code nutrition interventions in section M for resident #136, and failed to code turning and repositioning under section M for resident #105 and the facility Quality Improvement (QI) process The Administrator, Director of Nursing (DON) and QI Nurse were educated by the Corporate Consultant on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include coding diagnosis, nutrition and prevention interventions on the MDS on 11/30/2017. The Administrator, DON and QI Nurse were educated by the Corporate Consultant on the Quality Assurance (QA) process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 11/30/2017 by the Facility Nurse Consultant. The Administrator completed 100% audit of previous citations and action plans within the past year to include coding	

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F 520	Continued From page 54 staff interview, the facility failed to implement care plan interventions by failing to turn and reposition residents with pressure ulcers for 2 of 3 residents (Resident #136 and #105), failing to implement bunny boots for 1 of 3 residents with pressure ulcers (Resident # 136) and failed to do weekly skin assessments for 1 of 3 residents reviewed with pressure ulcers (Resident #105). F-282 was originally cited on 12/1/16 for failing to follow a care plan for a resident who was identified with weight loss, by failing to document refusals to participate in the restorative dining program and failing to offer a substitute for 1 of 1 resident reviewed for weight loss (Resident #151). On 11/16/17 at 3:54 PM the Administrator acknowledged understanding of the reciting of F-278 and F-282 during the recertification survey of 11/16/17. The Administrator stated since the last recertification survey of 12/01/16, there have been staffing changes with the Minimum Data Set (MDS) and had implemented that the MDS Nurses only do MDS to insure they would be accurate. She stated that the care guides were in the residents' closets and all staff knew to look at them before providing care. The Administrator stated she did not know why the nursing assistant failed to look at the care guide before giving care, but would continue to monitor to assure that staff go by the care guides. The Administrator stated she felt the repeat citations were related to the recent changes in the MDS staff and the facility was still in the process of correcting the identified concerns.	F 520	diagnosis, nutrition and prevention interventions on the MDS to ensure that the QI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QI Committee by the Administrator on 12/14/2017 for any concerns identified. All data collected for identified areas of concerns to include coding diagnosis, nutrition and prevention interventions on the MDS will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if the plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Administrator. The Corporate Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include coding diagnosis, nutrition and prevention interventions on the MDS and all current citations and QI plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QI nurse for any	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804

(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 520	Continued From page 55	F 520	identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	