| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345113 | A. BUILDING _____ B. WING _____ | C 04/26/2018 |

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| WILLOW CREEK NURSING AND REHABILITATION CENTER | 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 |

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| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to provide a bath for 1 of 1 residents (Resident #2). Findings included:<br><br>The quarterly Minimum Data Set (MDS) dated 04/06/18 revealed Resident #2 was readmitted to the facility on 09/25/17. Diagnoses on the MDS included anoxic brain damage, respiratory failure, and seizure disorder. Resident #2 had short and long term memory problems and was severely impaired in daily decision making. Resident #2 was totally dependent on one person for bathing.<br><br>Review of the Bath Type record dated 04/18/18 revealed no documentation that a bath was given to Resident #2 that day.<br><br>Review of Resident #2's Care Plan revised 04/19/18 revealed a focus on assistance for bathing related to hypoxic brain injury and quadriplegia. The goal through the next review was for Resident #2 to be neat, clean and odor free. Interventions included bed baths, and to make sure hair was washed and nails were manicured on Wednesdays.<br><br>In an interview on 04/25/18 at 8:17 AM Nursing Assistant (NA) #2 stated when a bath was provided to a resident it was documented in the | F 558 | F558<br>Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10 (e) (3)<br><br>The process that lead to the deficiency was based on record review and staff interviews the facility failed to provide a bath for 1 of 1 residents (resident #2).<br><br>100% audit of all residents bathing documentation, to include resident #2, for April 2018 by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and the RN supervisor to ensure baths are being provided, in addition to any other care assigned on shower/bath days, including nail care and hair washing was initiated on 5/3/2018. Any areas of concern identified during the audit will be immediately addressed by the Director of Nursing (DON) to include additional training of staff and will be completed by 5/3/2018.<br><br>100% in-service for all licensed nurses and nursing assistants (NA) to include agency, was initiated by the Staff | 5/14/18 |

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

Electronically Signed | 05/14/2018

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| F 558 | Continued From page 1<br>computer by the aide. She indicated Resident #2 was dependent on staff for bathing.<br><br>In a telephone interview on 04/25/18 at 1:05 PM NA #4 stated she had been assigned to care for Resident #2 on 04/18/18. She indicated she had been on her way to bathe Resident #2 when she was called to the Director of Nursing's (DON) office. She stated she had been unable to provide a bath to Resident #2 as required prior to clocking out that day because there was not enough staff to provide the needed care to the residents on the 700 hall.<br><br>In an interview on 04/25/18 at 3:25 PM Nurse #5 indicated Resident #2 received a daily bed bath. She stated Resident #2 perspired a lot and if not bathed daily an odor developed.<br><br>In an interview on 04/26/18 at 4:30 PM the DON stated she expected care to be provided per the choice of the resident, the responsible party, or the needs of the resident. She indicated that Resident #2 did perspire a lot and that a daily bath was needed to prevent an odor from developing. | F 558 | Facilitator on 5/2/2018, regarding providing all residents with showers or baths based on the resident preference, in addition to any other care assigned on shower/bath days, including nail care and hair washing. The showers must include documentation in the electronic medical record Point Click Care (PCC) and Point of Care (POC) to show that the shower/bath was provided. If a resident refuses, the nurse will be notified in order that the refusal will be documented in the resident□s progress note by the licensed nurse and will be completed by 5/3/2018.<br><br>10% of all residents□ documentation in PCC and POC will be reviewed by the ADON, the QI nurse and the RN supervisor to ensure showers/ baths are documented to include any additional care assigned on shower/bath days, such as nail care and hair washing, and refusals will be documented in the progress note by the licensed nurse, weekly for 8 weeks, then monthly for 1 month utilizing a Shower Documentation audit tool. Any areas of concern identified during the audit will be immediately addressed by the ADON, the QI nurse and/or the RN supervisor to include additional staff training. The Director of Nursing (DON) will review and initial the Shower Documentation audit tool weekly for 8 weeks and then monthly for one month to ensure all areas of concern were addressed.<br><br>The administrator will review and present the findings of the Shower Documentation | |

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| F 558 | Continued From page 2 | F 558 | audit tool to the Executive QI committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(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-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(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);<br>(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<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(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) | F 580 | | 5/14/18 |

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| F 580 | Continued From page 3<br>is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and physician interviews the facility failed to notify the physician that a urine sample was not obtained for analysis and sent to the laboratory as ordered for 1 of 1 sampled residents (Resident #1) with recurring urinary tract infection (UTI) symptoms. Findings included:<br><br>Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was cognitively intact. Resident #1 had diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD), and atrial fibrillation. | F 580 | F580<br>Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>The process that lead to the deficiency was based on record review and staff and physician interviews the facility failed to notify the physician that a urine sample was not obtained for analysis and sent to the laboratory as ordered for 1 of 1 sample residents (resident #1) with recurring urinary tract infection (UTI) | |

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| F 580 | Continued From page 4<br><br>Review of Resident #1's Care Plan created 10/18/17 revealed interventions of: observe for signs and symptoms of UTI and notify physician for possible intervention, obtain labs as ordered and notify physician of abnormal findings.<br><br>Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses of UTI and an acute exacerbation of COPD.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/03/17 at 9:47 AM revealed that Resident #1 had complained of a burning sensation on urination and that the physician had been made aware.<br><br>Review of the physician orders dated 12/03/17 revealed an order for a UA (urinalysis) and culture and sensitivity (C&S).<br><br>Review of the medical record from 12/03/17-12/22/17 revealed no results for the ordered UA and C&S.<br><br>Review of the Health Status nursing note dated 12/03/17 at 10:42 PM revealed Nurse #1 had attempted to obtain a urine sample but had been unsuccessful. The note indicated that Nurse #1 would make the oncoming nurse aware of Resident #1's burning on urination.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/09/17 at 10:54 AM revealed an order had been given for a UA with C&S.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/11/17 at 7:58 PM revealed Resident #1 had burning on urination and an order had been | F 580 | symptoms. Resident #1 no longer resides in the facility.<br><br>A 100% review of all residents progress notes will be completed by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, was initiated on 5/3/2018), to ensure appropriate documentation, to include, that the resident physician and resident representative (RR) has been notified of any significant change in residents condition to include when labs are ordered and the labs are unable to be obtained, for the last 30 days, 4/3/2018 to 5/3/2018.<br><br>The residents physician and/or RR will be notified of any identified areas of concern and the notification will be documented in the residents electronic medical record by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, and will be completed by 6/3/2018 utilizing a resident census.<br><br>An inservice was initiated for 100% of all licensed nurses, to include nurse #1 and #2 and #5, to include agency nurses, on 5/3/2018 by the Staff Facilitator regarding notification of physician and/or RR of any significant change in residents condition to include when labs are ordered and the labs are unable to be obtained and that documentation of notification to be entered into the residents medical record, will be completed by 5/4/2018. | |

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| F 580 | Continued From page 5<br>given for a UA with C&S.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/12/17 at 3:17 AM revealed the nurse was waiting to have the UA and C&S done.<br><br>In an interview on 04/24/18 at 3:38 PM Nurse #1 who worked with Resident #1 on 12/03/17 stated if a resident complained of burning on urination the nurse should notify the physician and get an order for a UA with C&S. She indicated when the results came back to the facility the physician should be notified of the result. Nurse #1 stated she had attempted to collect urine from Resident #1 but had not been successful. She indicated she informed the oncoming nurse that the urine sample was needed. She stated she did not follow-up to make sure the urine sample had been collected and sent to the laboratory. She stated she had not notified the physician that she had been unable to collect the urine sample.<br><br>In an interview on 04/25/18 at 1:55 PM the Director of Nursing (DON) verified that no urine sample had been sent to the laboratory for analysis as requested by the physician on 12/03/17.<br><br>In an interview on 04/25/18 at 3:05 PM Nurse #3 who cared for Resident #1 on 12/09/17 stated she did not remember getting an order for a urinalysis or obtaining a urine sample from Resident #1. After reviewing her note from 12/09/17 she indicated she must have received the information in report but that she did not call the physician or obtain the urine sample.<br><br>In an interview on 04/25/18 at 3:25 PM Nurse #5 stated if she was unable to collect a urine sample | F 580 | When there is any significant change in resident□s condition, to include when labs are ordered and the labs are unable to be obtained, the license nurse is responsible for notifying the resident physician and/or RR and documenting in the residents electronic medical records. The ADON, QI nurses and the RN supervisor will review 10% of residents progress notes, daily 3 times a week for 4 weeks then weekly x 4 weeks then monthly x 1 month to ensure appropriate documentation for notification of the physician and/or RR, for any changes in the resident, to include when labs are ordered and the labs are unable to be obtained, is recorded in the resident medical record utilizing a MD/RR notification QI Audit Tool. The ADON, QI nurses and the RN supervisor, will immediately notify the MD/RR for any identified areas of concern and document in the clinical record and provide retraining with the license nurse. The DON will review and initial the RR/MD notification QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed and documented in the electronic medical records and retraining provided with the responsible staff member.<br><br>The Executive QI committee will meet monthly and review the MD/RR notification QI Audit Tool to make changes as needed, to include continued frequency of monitoring x 3 months.<br><br>The Administrator and the DON will be | |

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| F 580 | Continued From page 6<br>she would notify the physician and get an order for a catheterized specimen. If still unable she would document and let the oncoming nurse know that a sample was still needed. She indicated she would check the next day to make sure the sample had been collected and sent to the laboratory. Nurse #5 stated if it had not been collected she would go to her supervisor and notify the physician to give him the opportunity to do another form of treatment.<br><br>In an interview on 04/25/18 at 5:09 PM Nurse #2 stated she was assisting Nurse #1 with charting on 12/11/17. She indicated Resident #1 told her during her assessment that she had been having burning on urination. Nurse #2 informed Nurse #1 and Nurse #1 told her she would call the physician and obtain an order for the urine test. Nurse #2 stated she did not call the physician to inform him of Resident #1's symptoms or that the previously ordered laboratory tests had not been completed. She indicated someone should have followed up on the missing urinalysis from 12/03/17 and notified the physician.<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated he expected his orders to be followed. He indicated the facility was usually good about notifying him of the results of the laboratory tests he ordered. He indicated he did not know what happened but he expected to be notified if laboratory tests could not be completed so other options could be explored.<br><br>In a follow-up interview on 04/26/18 at 4:15 PM the DON stated it was her expectation that orders for laboratory tests be completed as ordered. She indicated someone should have followed-up | F 580 | responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |

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| F 580 | Continued From page 7<br>on the missing UA and C&S and notified the physician that the tests were not done and that Resident #1 continued to have UTI symptoms. | F 580 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document | F 656 | | 5/14/18 |

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| F 656 | Continued From page 8<br>whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and physician interviews the facility failed to implement the comprehensive Care Plan for 1 of 1 residents (Resident #1) investigated for Urinary Tract Infection (UTI) and respiratory medications. Findings included:<br><br>Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was admitted to the facility with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), heart failure, and atrial fibrillation. Resident #1 was frequently incontinent of bladder and was cognitively intact.<br><br>A. Review of Resident #1's Care Plan initiated 10/18/17 revealed a focus on occasional urinary incontinence related to decreased mobility and the loss of bladder sensation. Interventions included to observe for signs of UTI and to notify the physician for possible interventions if symptoms were observed. Interventions also included to obtain laboratory results as ordered and to notify the physician of abnormal findings.<br><br>In an interview on 04/25/18 at 1:55 PM the Director of Nursing (DON) verified that a urine sample had not been sent to the laboratory for analysis by the facility in December 2017 as | F 656 | F656<br>Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>The process that lead to the deficiency was based on record review and staff and physician interviews the facility failed to implement the comprehensive care plan for 1 of 1 residents (resident #1) investigated for Urinary tract infections (UTI) and respiratory medications. Resident #1 no longer resides in the facility.<br><br>Part A<br>A 100% review of all residents progress notes will be completed by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, was initiated on 5/3/2018), to ensure appropriate documentation, to include, that the resident physician and resident representative (RR) has been notified of any significant change in residents condition to include when labs are ordered, to include urine for complaints of burning on urination in | |

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| F 656 | Continued From page 9<br>requested by the physician on 12/03/17.<br><br>In an interview on 04/26/18 at 3:24 PM the MDS Coordinator stated the Care Plan was a very important part of the Resident's plan of care. She indicated the Care Plan directed what care the resident needed and that it was a problem if the Care Plan was not followed.<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated he expected to be notified if laboratory tests were not collected so other options could be explored.<br><br>In an interview on 04/26/18 at 4:15 PM the DON stated she expected the Care Plan to be followed. She indicated she expected all treatments and laboratory tests to be completed and that care be provided to the residents as directed by the Care Plan and the physician.<br><br>B. Review of Resident #1's Care Plan initiated 10/12/17 revealed a focus on a potential for ineffective breathing patterns related to COPD and congestive heart failure (CHF). Interventions included the administration of nebulizer treatments as ordered by the physician.<br><br>Review of the 11/27/17 and the December 2017 Medication Administration Record (MAR) revealed Duoneb via nebulizer every 4 hours was not administered.<br><br>In an interview on 04/26/18 at 3:24 PM the MDS Coordinator stated the Care Plan was a very important part of the Resident's plan of care. She indicated the Care Plan directed what care the resident needed and that it was a problem if the Care Plan was not followed. | F 656 | accordance with the resident care plan, and when the labs are unable to be obtained for the last 30 days, 4/3/2018 to 5/3/2018. The resident□s physician and/or RR will be notified of any identified areas of concern and the notification will be documented in the resident□s medical record by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, and will be completed by 6/3/2018 utilizing a resident census.<br>An inservice was initiated for 100% of all licensed nurses, to include nurse #1, #2, #3 and #5, to include agency nurses, on 5/3/2018 by the Staff Facilitator regarding when there is any significant change in resident□s condition, to include when labs are ordered, to include urine for complaints of burning on urination in accordance with the residents care plan, and the labs are unable to be obtained, the license nurse is responsible for notifying the resident physician and/or RR and documenting in the residents electronic medical records and will be completed by6/3/20018.<br><br>The ADON, QI nurses and the RN supervisor will review 10% of residents progress notes, daily 3 times a week for 4 weeks then weekly x 4 weeks then monthly x 1 month to ensure appropriate documentation for notification of the physician and/or RR, for any changes in the resident, to include when labs are ordered, to include urine for complaints of burning on urination in accordance with the residents care plan, and the labs are | |

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| F 656 | Continued From page 10<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated he expected his orders to be followed and all medications and treatments be provided.<br><br>In an interview on 04/26/18 at 4:15 PM the DON stated she expected the Care Plan to be followed. She indicated she expected all medications and treatments to be administered and that care be provided to the residents as directed by the Care Plan and the physician. | F 656 | unable to be obtained, is recorded in the resident medical record utilizing a MD/RR notification QI Audit Tool. The ADON, QI nurses and the RN supervisor, will immediately notify the MD/RR for any identified areas of concern and document in the clinical record and provide retraining with the license nurse. The DON will review and initial the RR/MD notification QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed and documented in the electronic medical records and retraining provided with the responsible staff member.<br><br>The Executive QI committee will meet monthly and review the MD/RR notification QI Audit Tool to make changes as needed, to include continued frequency of monitoring x 3 months.<br><br>Part B<br>100% audit, was initiated on 5/2/2018 of all current residents Medical Administration Records (MARs) will be reviewed and compared to the discharge summaries and physician written/telephone orders, by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and the RN supervisor for the past 30 days 4/2/2018 to 5/2/2018 to ensure all medication orders, to include Duonebs treatments, have been transcribed correctly to the resident MAR for administration of the medication in accordance with the resident care plan. Any areas of concern | |

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| F 656 | Continued From page 11 | F 656 | identified during the audit will be immediately addressed by the Director of Nursing (DON) to include additional re-training of staff and will be completed by 6/2/2018.<br><br>A 100% in-servicing with all licensed nurses, to include nurse #1 and #2, to include agency nurses, was initiated by the Staff Facilitator on 5/2/2018 regarding correctly transcribing all physician orders, to include following orders from the discharge summary, to the MAR to ensure all medications are transcribed, to include Duonebs, and administered correctly in accordance with the resident care plan and will be completed by 5/4/2018.<br><br>10% of residents MARs will be reviewed by the ADON, the QI nurse and the RN supervisor, to compare to all physician orders, to include the discharge summary to the resident MAR to ensure all medication orders, to include Duonebs, are transcribed correctly to the resident MAR for administration of the medication in accordance with the resident care plan will occur weekly for 8 weeks, then monthly for 1 month, utilizing a Medication Transcription Audit tool. The Director of Nursing (DON) will review and initial the Medication Transcription Audit tool weekly for 8 weeks and then monthly for one month for completion and to ensure all areas of concern were addressed.<br><br>The administrator and/or the DON will review and present the findings of the Medication Transcription Audit tool and | |

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| F 656 | Continued From page 12 | F 656 | the MD/RR notification QI Audit Tool to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews the facility failed to rinse the soap from a resident's body after bathing for 1 of 1 residents (Resident #2). Findings included:<br><br>The quarterly Minimum Data Set (MDS) dated 04/06/18 revealed Resident #2 was readmitted to the facility on 09/25/17. Diagnoses on the MDS included anoxic brain damage, respiratory failure, and seizure disorder. Resident #2 had short and long term memory problems and was severely impaired in daily decision making. Resident #2 was totally dependent on one person for bathing.<br><br>Review of Resident #2's Care Plan revised 04/19/18 revealed a focus on assistance for | F 677 | F677<br>ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>The process that lead to the deficiency was based on observation, record review and staff interviews the facility failed to rinse the soap from a resident□s body after bathing for 1 of 1 residents (resident #2).<br><br>100% observation of all licensed nurses and nursing assistants (NA), to include NA #3, by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) | 5/14/18 |

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| F 677 | Continued From page 13<br>bathing related to hypoxic brain injury and quadriplegia. The goal through the next review was for Resident #2 to be neat, clean and odor free. Interventions included bed baths, and to make sure hair was washed and nails were manicured on Wednesdays.<br><br>In an observation of bathing on 04/26/18 at 11:05 AM Nursing Assistant (NA) #3 provided privacy for Resident #2. A basin of warm water was brought to the bedside. A washcloth was dipped in the water and NA #3 washed Resident #2's face. Body wash was applied to the washcloth and the cloth was placed into the basin of water. Multiple soapy washcloths were used to wash Resident #2's body and the same soapy water was used to rinse her body. NA #3 did not use clear water to rinse the soap from Resident #2's body during the bath.<br><br>Immediately following the bath the directions on the shampoo and body wash provided for Resident #2's bath was reviewed. The directions revealed: "Moisten scalp, skin, or washcloth. Apply gel, lather and rinse thoroughly."<br><br>In an interview on 04/26/18 at 11:40 AM NA #3 stated it was her first day off of orientation. After reading the directions on the shampoo and body wash she stated she had not rinsed the soap from Resident #2's body. She indicated it was very important to rinse the soap off the body because it could cause an infection.<br><br>In an interview on 04/26/18 at 4:15 PM the DON indicated it was her expectation that aides rinse the soap off of residents they were bathing unless it was specified as a no rinse soap. | F 677 | nurses, the RN supervisor and/or the Staff Facilitator on giving a bath to a resident, to include resident #2, to ensure correct procedure is being followed to include rinsing off soap if a no rinse soap is not used during the bath and will be completed by 5/2/2014 utilizing a Resident Care audit tool for bath observation.<br><br>An inservice for 100% of all licensed nurses and NA□s, to include NA #3 was initiated by the Staff Facilitator on 5/3/2014 regarding the correct procedure for giving a resident a bath to include rinsing off the soap unless a no rinse soap is used and will be completed by 5/4/2018.<br><br>10% of all licensed nurses and NA□s, to include NA #3, will be observed giving a bath to a resident, to include resident #2, by the ADON, QI nurses, the RN supervisor and/or the Staff Facilitator to ensure that the correct procedure for giving a bath, to include rinsing off the soap, is being followed, weekly for 8 weeks and then monthly for one month utilizing a Resident Care audit tool for bath observations. The Director of Nursing (DON) will review and initial the Resident Care audit tool for bath observations weekly for 8 weeks and then monthly for one month to ensure all areas of concern were addressed.<br><br>The administrator will review and present the findings of the Resident Care audit tool to the Executive QI committee monthly for 3 months. Any issues, | |

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| F 677 | Continued From page 14 | F 677 | concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore | F 690 | | 5/14/18 |

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| F 690 | Continued From page 15<br>continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and physician interviews the facility failed to obtain a urine sample for urinalysis and culture and sensitivity as ordered by the physician for 1 of 1 residents (Resident #1) who experienced burning on urination. Findings included:<br><br>Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was cognitively intact. Resident #1 had diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD), and atrial fibrillation.<br><br>Review of Resident #1's Care Plan created 10/18/17 revealed interventions of: observe for signs and symptoms of Urinary Tract Infection (UTI) and notify physician for possible intervention, obtain labs as ordered and notify physician of abnormal findings.<br><br>Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses UTI and an acute exacerbation of COPD.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/03/17 at 9:47 AM revealed that Resident #1 had complained of a burning sensation on urination and that the physician had been made | F 690 | F690<br>Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>The process that lead to the deficiency was based on record review and staff and physician interviews the facility failed to obtain a urine sample for urinalysis and culture and sensitivity as ordered by the physician for 1 of 1 residents (resident #1) who experienced burning on urination.<br><br>A 100% review of all residents progress notes will be completed by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, was initiated on 05/03/2018, to ensure appropriate documentation, to include, that the resident physician and resident representative (RR) has been notified of any significant change in residents condition to include when labs are ordered, to include urine for complaints of burning on urination, and when the labs are unable to be obtained, for the last 30 days, 04/03/2018 to | |

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| F 690 | Continued From page 16<br>aware.<br><br>Review of the Physician Orders dated 12/03/17 revealed an order to obtain a urine sample for a urinalysis (UA) and culture and sensitivity (C&S). This was the only facility order for UA and C&S in December 2017.<br><br>Review of the medical record from 12/03/17-12/22/17 revealed no results for the ordered UA and C&S.<br><br>Review of the Health Status nursing note dated 12/03/17 at 10:42 PM revealed Nurse #1 had attempted to obtain a urine sample but had been unsuccessful. The note indicated that Nurse #1 would make the oncoming nurse aware of Resident #1's burning on urination.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/09/17 at 10:54 AM revealed an order had been given for a UA with C&S.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/11/17 at 7:58 PM revealed Resident #1 had burning on urination and an order had been given for a UA with C&S.<br><br>Review of the Skilled/Post-Acute nursing note dated 12/12/17 at 3:17 AM revealed the nurse was waiting to have the UA and C&S done.<br><br>In an interview on 04/24/18 at 3:38 PM Nurse #1 who worked with Resident #1 on 12/03/17 stated if a resident complained of burning on urination the nurse should notify the physician and get an order for a UA with C&S. She indicated when the results came back to the facility the physician should be notified of the result. Nurse #1 stated | F 690 | 05/03/2018. The resident□s physician and/or RR will be notified of any identified areas of concern and the notification will be documented in the resident□s medical record by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and/or RN supervisor, and will be completed by 06/03/2018 utilizing a resident census.<br><br>An inservice was initiated for 100% of all licensed nurses, to include nurse #1, #2, #3 and #5, to include agency nurses, on 05/03/2018 by the Staff Facilitator regarding notification of physician and/or RR of any significant change in resident□s condition to include when labs are ordered, to include urine for complaints of burning on urination, and the labs are unable to be obtained and that documentation of notification to be entered into the resident□s medical record, will be completed by 05/04/2018.<br><br>When there is any significant change in resident□s condition, to include when labs are ordered, to include urine for complaints of burning on urination, and the labs are unable to be obtained, the license nurse is responsible for notifying the resident physician and/or RR and documenting in the residents electronic medical records. The ADON, QI nurses and the RN supervisor will review 10% of residents progress notes, daily 3 times a week for 4 weeks then weekly x 4 weeks then monthly x 1 month to ensure appropriate documentation for notification of the physician and/or RR, for any | |

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| F 690 | Continued From page 17<br>she had attempted to collect urine from Resident #1 but had not been successful. She indicated she informed the oncoming nurse that the urine sample was needed. She stated she did not follow-up to make sure the urine sample had been collected and sent to the laboratory.<br><br>In an interview on 04/25/18 at 1:55 PM the Director of Nursing (DON) verified that no urine sample had been sent to the laboratory for analysis as requested by the physician on 12/03/17.<br><br>In an interview on 04/25/18 at 3:05 PM Nurse #3 who cared for Resident #1 on 12/09/17 stated she did not remember getting an order for a urinalysis or obtaining a urine sample from Resident #1. After reviewing her note from 12/09/17 she indicated she must have received the information in report but that she did not call the physician or obtain the urine sample.<br><br>In an interview on 04/25/18 at 5:09 PM Nurse #2 stated she was assisting Nurse #1 with charting on 12/11/17. She indicated Resident #1 told her during her assessment that she had been having burning on urination. Nurse #2 informed Nurse #1 and Nurse #1 told her she would call the physician and obtain an order for the urine test. Nurse #2 stated she did not call the physician to inform him of Resident #1's symptoms or that the previously ordered laboratory tests had not been completed. She indicated someone should have followed up on the missing urinalysis from 12/03/17.<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated he expected his orders to be followed. He indicated the facility | F 690 | changes in the resident, to include when labs are ordered, to include urine for complaints of burning on urination, and the labs are unable to be obtained, is recorded in the resident medical record utilizing a MD/RR notification QI Audit Tool. The ADON, QI nurses and the RN supervisor, will immediately notify the MD/RR for any identified areas of concern and document in the clinical record and provide retraining with the license nurse. The DON will review and initial the RR/MD notification QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed and documented in the electronic medical records and retraining provided with the responsible staff member.<br><br>The Executive QI committee will meet monthly and review the MD/RR notification QI Audit Tool to make changes as needed, to include continued frequency of monitoring x 3 months.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |

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| F 690 | Continued From page 18<br>was usually good about notifying him of the results of the laboratory tests he ordered. He indicated he did not know what happened but he expected to be notified if laboratory tests could not be completed so other options could be explored.<br><br>In a follow-up interview on 04/26/18 at 4:15 PM the DON stated it was her expectation that orders for laboratory tests be completed as ordered. She indicated someone should have followed-up on the missing UA and C&S. | F 690 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff, family, and physician interviews the facility failed to provide respiratory medications as ordered by the physician for 1 of 1 residents (Resident #1) whose medications were reviewed. Findings included:<br><br>Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was cognitively intact. Resident #1 had admission diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD), and atrial fibrillation. | F 695 | F695<br>Respiratory/Tracheostomy Care and Suctioning<br>CFR(s): 483.25(i)<br><br>The process that lead to the deficiency was based on record and staff, family, and physician interviews the facility failed to provide respiratory medications as ordered by the physician for 1 of 1 residents (resident #1). Resident #1 no longer resides in the facility. | 5/14/18 |

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| WILLOW CREEK NURSING AND REHABILITATION CENTER | 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 |

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| F 695 | Continued From page 19<br><br>Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses of Urinary Tract Infection (UTI) and an acute exacerbation of COPD.<br><br>Review of the hospital Discharge Summary dated 11/27/17 under Prescriptions: Continue, revealed an order for Ipratropium/Albuterol (Duoneb) 3 ml (milliliters) via a nebulizer every 4 hours.<br><br>Review of the handwritten 11/27/17-11/30/17 Medication Administration Record (MAR) revealed no order for the administration of Duoneb every 4 hours.<br><br>Review of Resident #1's 12/01/17-12/31/17 MAR revealed a computer generated order for Duoneb dated 11/14/17 with no scheduled times for administration but PRN (as needed) was written next to the medication.<br><br>Review of the December 2017 Health Status nursing notes revealed Resident #1 had labored respirations at times, was short of breath at times and that nebulizer treatments and oxygen were given as needed.<br><br>In a telephone interview on 04/24/18 at 4:57 PM Resident #1's family member stated both she and Resident #1 had told the nurses numerous times that the Resident was supposed to be getting regular nebulizer breathing treatments.<br><br>In an interview on 04/25/18 at 2:11 PM the Consultant Pharmacist stated when she performed the monthly pharmacy reviews for the residents she looked at any recent hospital discharge summaries for medications, reviewed | F 695 | 100% audit, was initiated on 4/25/2018 of all current residents Medical Administration Records (MARs) will be reviewed and compared to the discharge summaries and physician written/telephone orders, by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and the RN supervisor for the past 30 days. 4/25/2018 to 5/25/2018 to ensure all medication orders, to include Duonebs treatments, have been transcribed correctly to the resident MAR. Any areas of concern identified during the audit will be immediately addressed by the Director of Nursing (DON) to include additional training of staff and will be completed by 6/25/2018.<br><br>100% in-servicing with all licensed nurses, to include nurse #1 and #2, to include agency nurses, was initiated by the Staff Facilitator on 5/2/2018 regarding correctly transcribing all physician orders, to include following orders from the discharge summary, to the MAR to ensure all medications are transcribed, to include Duonebs, and administered correctly and will be completed by5/4/2018.<br><br>10% of residents MARs will be reviewed by the ADON, the QI nurse and the RN supervisor , to compare all physician orders, to include duoneds and the discharge summary to the resident MAR to ensure all medication orders are transcribed correctly weekly for 8 weeks, then monthly for 1 month, utilizing a | |

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| F 695 | Continued From page 20<br>the Physician Order sheets, and looked for any new orders from the physician. She indicated she did not review the paper MAR that the nurses kept on their carts. She indicated when a resident was re-admitted to the facility from the hospital all previous orders were discontinued and the new orders were put in place. She stated when she reviewed Resident #1's record in December 2017, the hospital discharge medications listed Duoneb to be given every 4 hours. She stated when she looked at the Physician Order sheets for December she saw that the Duoneb was listed to be given every 4 hours and that there had been no change in orders written for the Duoneb.<br><br>In an interview on 04/25/18 at 5:09 PM Nurse #2 indicated Resident #1 and Resident #1's family member had informed her several times that Resident #1 was supposed to get regular breathing treatments but that she had not checked the orders or called the physician for clarification.<br><br>In an interview on 04/26/18 at 10:54 AM Nurse #1 stated she had transcribed Resident #1's Hospital Discharge orders to the 11/27/17 MAR. She indicated another nurse should have checked the MAR for errors or omissions but did not know if it had been done since there were no nurse signatures. She indicated she did not write PRN next to the Duoneb order on the December 2017 MAR.<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated when a resident was re-admitted to the facility from the hospital he expected the hospital discharge orders to be followed. He indicated that Duoneb was a | F 695 | Medication Transcription Audit tool. The Director of Nursing (DON) will review and initial the Medication Transcription Audit tool weekly for 8 weeks and then monthly for one month for completion and to ensure all areas of concern were addressed.<br><br>The administrator and/or the DON will review and present the findings of the Medication Transcription Audit tool to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |

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| F 695 | Continued From page 21<br>bronchodilator (used to open the breathing passages) and that Resident #1 should have received scheduled breathing treatments if that was what was ordered. He indicated if there were any questions the facility was usually pretty good about calling him to ask for clarification.<br><br>In an interview on 04/26/18 at 4:15 PM the Director of Nursing (DON) stated she expected medications to be transcribed correctly from the hospital discharge summary and for medications to be administered as ordered. She indicated if there were questions she expected the nurse to call the physician to clarify the orders. | F 695 | | |
| F 725 SS=D | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not | F 725 | | 5/14/18 |

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| F 725 | Continued From page 22<br>limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to ensure a sufficient number of Nursing Assistants (NAs) to provide care and respond to each resident's needs for 1 of 1 residents (Resident #2). Findings included:<br><br>The quarterly Minimum Data Set (MDS) dated 04/06/18 revealed Resident #2 was readmitted to the facility on 09/25/17. Diagnoses on the MDS included anoxic brain damage, respiratory failure, and seizure disorder. Resident #2 had short and long term memory problems and was severely impaired in daily decision making. Resident #2 was totally dependent on one person for bathing.<br><br>Review of the Daily Schedule revealed four NA's had been assigned to work on the 500 and 700 halls on day shift 04/18/18. One aide was shown to have left early. There was also one NA orienting to the unit that day.<br><br>Review of the Daily Assignment sheet dated 04/18/18 revealed NA #1, with the NA orientee, was assigned to care for the residents in rooms 501-503A and 701-705, NA #4 was assigned to care for the residents in rooms 706-715, and NA #5 was assigned to care for the residents in rooms 503B-511. The Daily Assignment sheet did not reflect an assignment for the aide that left early. | F 725 | F725<br>CFR (s): 483.35 (a) (1) (2)<br>The process that lead to the deficiency was based on record review and staff interviews the facility failed to ensure a sufficient number of Nursing Assistants (NAs) to provide care and respond to each residents needs for 1 of 1 resident (resident #2).<br><br>On 05/14/2018, the Director of Nursing (DON) and the Administrator reviewed the clinical staffing schedule to ensure that sufficient staff were on duty to meet the care needs of the residents, to providing showers/baths, per resident preferences, to include for Resident #2. The DON will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to ensure that clinical staff are on duty to meet the needs of the residents. The weekly case mix index will be reviewed weekly to ensure the acuity of the residents is taken into account with the clinical staffing patterns to meet the needs of the residents, including the needs of Resident #2.<br><br>On 05/14/2018, the Facility Nurse Consultant in-serviced the Administrator and the DON in regards to Sufficient Staff | |

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| F 725 | Continued From page 23 | F 725 | | |

Review of the Bath Type record dated 04/18/18 revealed no documentation that a bath was given to Resident #2 that day.

In an interview on 04/25/18 at 9:40 AM Nurse #4 stated she had not been told by any aides on 04/18/18 that they were unable to provide care to the residents because they did not have enough staff.

In a telephone interview on 04/25/18 at 1:05 PM NA #4 stated she had been the only aide who worked on the 700 hall on day shift on 04/18/18. She indicated there was an orientee who worked on the hall but not another aide. She indicated she had not been able to provide a bath to Resident #2 because she had been too busy providing care to other residents and answering call lights.

In an interview on 04/25/18 at 4:55 PM the Scheduler stated there were four aides and an orientee scheduled to work the day shift on 04/18/18 on the 500 and 700 halls. She indicated NA #6 had to leave early due to an emergency leaving three aides and the orientee to cover the 500 and 700 halls. The Scheduler stated she sent the Restorative NAs (RNA) to assist with the assignment. She indicated that after review of the documentation for 04/18/18 RNA #1 had bathed Resident #2.

In an interview on 04/26/18 at 12:00 PM RNA #1 stated she did not bathe Resident #2 on 04/18/18 and that she had not been pulled to work on the 700 hall as an aide.

In an interview on 04/26/18 at 12:10 PM RNA #2 stated she did not give a bath to Resident #2 on

to include:

1. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24 hour basis to provide nursing care to all residents in accordance with resident care plan.

2. The determination of sufficient staff will be made based on the staff□s ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being.
The facility has hired additional licensed nurses and nursing assistants to fill the vacant position in the current schedule. The facility will utilize agency staffing to ensure daily staffing is sufficient according to the acuity level of the residents and to ensure the needs of residents are met including for Resident #1.

The scheduling coordinator will be notified of night and weekend call-ins and no shows promptly. The scheduling coordinator will make necessary arrangements to ensure adequate staff are on duty. If the scheduling coordinator is unable to obtain adequate staff or if it is outside of the scheduling coordinators normal working hours, the ADON or the DON will be notified promptly. The facility administrator and DON will provide ongoing monitoring daily to ensure that there is adequate clinical staff on duty to provide needed care to residents that enable them to reach their highest practical physical, mental and

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| F 725 | Continued From page 24<br>04/18/18 and had not been given a hall assignment.<br><br>In an interview on 04/26/18 at 12:12 PM RNA #3 indicated she did not bathe Resident #2 on 04/18/18 and was not given a hall assignment.<br><br>In an interview on 04/26/18 at 1:50 PM Nurse #6 indicated the hall nurses were responsible for making sure the Daily Assignment sheet was updated to reflect the correct assignments and distribution of care.<br><br>In an interview on 04/26/18 at 1:55 PM NA #6 indicated she left the facility at about 8:30 AM on 04/18/18. She indicated she had informed the nurse that she had not completed her assigned baths for that day. She indicated she had never had to work as the only aide on the hall.<br><br>In an interview on 04/26/18 at 2:40 PM the NA Orientee stated that 04/18/18 was her first day of orientation. She indicated she and NA #4 were the only aides who worked day shift on the 700 hall that day.<br><br>In an interview on 04/26/18 at 2:42 PM NA #1 verified that the Daily Assignment sheet was incorrect and that she did not work on the 700 hall on day shift on 04/18/18. She indicated she was concerned that the NA Orientee was going to quit that day due to the 700 hall being short staffed.<br><br>In a follow-up interview on 04/26/18 at 4:25 PM the Scheduler stated that Mondays, Wednesdays, and Fridays were the most common days for call-outs. If there were call-outs staff was moved around to cover assignments, staff was asked to | F 725 | psychosocial wellbeing.<br><br>On 05/14/2018, all licensed nurses and nursing assistants were in-serviced that the scheduling coordinator is the first point of contact for any and all scheduling issues that arise while on shift and procedure for notifying the ADON or DON after hours and on weekends for further scheduling issues. The ADON & DON's contact information will be posted in designated employee areas and will include subsequent points of contact which will be available 24/7 to avoid a single point of failure.<br><br>All newly hired licensed nurses and nursing assistants will be in-serviced during orientation by the Staff Facilitator that the scheduling coordinator is the first point of contact for any and all scheduling issues that arise while on shift and procedure for notifying the ADON or DON after hours and on weekends for further scheduling issues. Copy of contact information for schedule related issues will be posted in designated areas.<br><br>The Administrator and/ or the DON will audit staffing schedule at the beginning of each shift to include nights and weekends x 4 weeks then twice weekly x 4 weeks then monthly x 1 month utilizing the Sufficient Staff Audit Tool to ensure sufficient staff to meet the needs of the residents based upon the acuity level as identified by the Case Mix index score assuring the residents reach their highest practicable physical, mental and | |

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| F 725 | Continued From page 25<br>stay over, or staff was called in to work. The Scheduler stated the facility used a "dot" system which required staff to work extra hours twice each month on assigned days if needed. She indicated there were usually four aides who worked the 500 and 700 hall assignments on each shift for day and evening shifts and three aides on night shift. She indicated she did not fill out the Daily Assignment sheets and was unable to verify who actually worked on the700 hall on 04/18/18. She stated it was the responsibility of the hall nurses to document the aide assignments on the Daily Assignment sheets.<br><br>In an interview on 04/26/18 at 4:30 PM the Director of Nursing (DON) stated she expected staff assignments to be filled using the "dot" system for call-outs and that all residents be cared for. | F 725 | psychosocial well-being. All areas of concern will be immediately addressed by the DON/Administrator to include use of administrative nurses pulled to the hall to meet resident care needs.<br><br>The Administrator will initial the Sufficient Staff Tool daily to assure the staffing patterns are appropriate to meet the needs of the resident care identified by their acuity level from the Case Mix Index Report.<br><br>The Administrator will forward the results of Sufficient Staff Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Sufficient Staff Audit Tool to determine trends and / or issues that may need further attention.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and physician interviews the facility failed to provide 138 doses of an ordered scheduled respiratory medication | F 760 | F760<br>Residents are Free of Significant Med Errors | 5/14/18 |

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| F 760 | Continued From page 26<br>(Duoneb) which resulted in a significant medication error for 1 of 1 residents (Resident #1) whose medications were reviewed. Findings included:<br><br>Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was cognitively intact. Resident #1 had admission diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD), and atrial fibrillation.<br><br>Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses of Urinary Tract Infection (UTI) and an acute exacerbation of COPD.<br><br>Review of the hospital Discharge Summary dated 11/27/17 under Prescriptions: Continue, revealed an order for Ipratropium/Albuterol (Duoneb) 3 ml (milliliters) via a nebulizer every 4 hours.<br><br>Review of the 11/27/17-11/30/17 Physician's Order sheets, where the hospital discharge medications were hand written, revealed no entry for the Duoneb. The Physician Orders had not been signed off by any nurses.<br><br>Review of the 11/27/17-11/30/17 Medication Administration Record (MAR) revealed no entries for the administration of Duoneb every 4 hours.<br><br>Review of the 12/01/17-12/31/17 Physician Order sheets revealed a computer generated order dated 11/14/17 for Duoneb to be given every 4 hours using a nebulizer. There were no scheduled times for administration of the Duoneb.<br><br>Review of Resident #1's 12/01/17-12/31/17 MAR revealed the signatures of Nurse #1 and Nurse | F 760 | CFR(s): 483.45(f) (2)<br><br>The process that lead to the deficiency was based on record review and staff and physician interviews the facility failed to provide 138 doses of an ordered scheduled respiratory medication (Duoneb) which resulted in a significant medication error for 1 of 1 residents (resident #1) whose medications were reviewed.<br><br>100% audit, was initiated on 5/2/2018 of all current residents Medical Administration Records (MARs) will be reviewed and compared to the discharge summaries and physician written/telephone orders, by the Assistant Director of Nursing (ADON), the Quality Improvement (QI) nurses and the RN supervisor for the past 30 days, 4/3/2018 to 5/3/2018 to ensure all medication orders, to include Duonebs treatments, have been transcribed correctly to the resident MAR. Any areas of concern identified during the audit will be immediately addressed by the Director of Nursing (DON) to include additional training of staff and will be completed by 5/4/2018.<br><br>On 5/2/2018, a 100% medication pass audit with all licensed nurses, to include nurse #1 and #2, to include agency nurses, and medication aides on proper medication administration to include five rights was initiated by the Staff Facilitator to ensure proper medication | |

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| F 760 | Continued From page 27<br>#2 signifying that the orders had been checked prior to 12/01/17 and were the most current and correct orders. The computer generated order for the Duoneb dated 11/14/17 was on the MAR and no scheduled times for administration were noted. Instead, PRN (as needed) was handwritten next to the order.<br><br>In an interview on 04/25/18 at 2:11 PM the Consultant Pharmacist stated when she performed the monthly pharmacy reviews for the residents she looked at any recent hospital discharge summaries for medications, reviewed the Physician Order sheets, and looked for any new orders from the physician. She indicated she did not review the paper MAR that the nurses kept on their carts. She indicated when a resident was re-admitted to the facility from the hospital all previous orders were discontinued and the new orders were put in place. She stated when she reviewed Resident #1's record in December 2017, the hospital discharge medications listed Duoneb to be given every 4 hours. She stated when she looked at the Physician Order sheets for December she saw that the Duoneb was listed to be given every 4 hours and that there had been no change in orders written for the Duoneb. The Consultant Pharmacist stated that she considered not administering 138 doses of Duoneb to be a significant medication error.<br><br>In an interview on 04/26/18 at 10:40 AM M Nurse #2 stated that at the end of the month two nurses checked the next month's MAR to make sure the most current orders were correctly listed. She confirmed that she had signed off as having done the second check on Resident #1's December 2017 MAR. She confirmed that she did not write | F 760 | administration. The licensed nurse□s medication pass observations included the administration of Duonebs per MD order. Any issues identified during the medication pass audit was immediately corrected with retraining of the license nurse or medication aide by the Staff Facilitator.<br><br>100% in-servicing with all licensed nurses, to include nurse #1 and #2, to include agency nurses, was initiated by the Staff Facilitator on 5/2/2018 regarding correctly transcribing all physician orders, to include following orders from the discharge summary, to the MAR to ensure all medications are transcribed, to include Duonebs, and administered correctly in accordance with the resident care plan, and will be completed by 5/4/2018.<br><br>On 5/2/2018, 100% in-service to all licensed nurses, to include nurse #1 and #2, to include agency nurses and medication aides was initiated by the Staff Facilitator regarding appropriate medication administration to include the five rights. All newly hired nurses will be in-serviced by the Staff Facilitator on appropriate medication administration, including the Five Rights, to include the administration of Duonebs per MD order in orientation. All newly hired medication aides will be in-serviced by Staff Facilitator on appropriate medication administration to include five rights in orientation.<br><br>10% of residents□ MARs will be reviewed | |

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|---|---|---|---|---|
| F 760 | Continued From page 28<br>the scheduled administration times for the Duoneb but stated she did not write PRN next to the Duoneb order indicating it be given as needed instead of scheduled. She stated she did not know who had written PRN next to the Duoneb order.<br><br>In an interview on 04/26/18 at 10:54 AM Nurse #1 stated she had transcribed Resident #1's Hospital Discharge orders to the 11/27/17 MAR but did not sign them. She indicated she did not know if another nurse had checked the orders but verified there was no second nurse signature and that another nurse should have checked the orders for errors or omissions. She indicated she had done the first check on Resident #1's December 2017 MAR and that she did not write PRN next to the medication. She indicated she had also not written the scheduled administration times for the Duoneb on the MAR. Nurse #1 indicated she did not know who had written PRN next to the Duoneb on the MAR.<br><br>In a telephone interview on 04/26/18 at 3:43 PM Resident #1's Physician stated when a resident was re-admitted to the facility from the hospital he expected the hospital discharge orders to be followed. He indicated that Duoneb was a bronchodilator (used to open the breathing passages) and that missing that many doses of the ordered medication was a significant medication error.<br><br>In an interview on 04/26/18 at 4:15 PM the Director of Nursing (DON) stated she expected medications to be transcribed correctly from the hospital discharge summary. She indicated if there were questions she expected the nurse to call the physician to clarify the orders. She stated | F 760 | by the ADON, the QI nurse and the RN supervisor , to compare all physician orders, to include Duonebs and the discharge summary to the resident MAR to ensure all medication orders are transcribed correctly weekly for 8 weeks, then monthly for 1 month, utilizing a Medication Transcription Audit tool. The Director of Nursing (DON) will review and initial the Medication Transcription Audit tool weekly for 8 weeks and then monthly for one month for completion and to ensure all areas of concern were addressed.<br><br>The QI Medication Pass Audit Tool will be utilized by the Staff Facilitator two times per week for 4 weeks; then weekly for 4 weeks; then monthly X1 month for all nurses, all three shifts, to include weekends, to ensure all licensed nurses, to include nurse #1 and #2, to include agency nurses, and medication aides are in compliance with medication administration and the five rights. The licensed nurse□s observation to include Nurse #1 and #2 will include administration of Duonebs per MD order. The DON will review and initial the QI Medication Pass Audit Tool for appropriate medication administration, to include administration of Duonebs to residents for compliance weekly for 8 weeks; then weekly X4 weeks; then monthly X1 month. Immediate retraining will be conducted for the licensed nurse, to include agency nurses and/r medication aide for any identified issues observed during the medication pass audits by the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345113 | A. BUILDING _____ B. WING _____ | C 04/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 760 | Continued From page 29<br>she expected two nurses to sign off the monthly reconciliation of orders and for those orders to be correct. She stated that that many missed doses of Duoneb was a significant error. | F 760 | Staff Facilitator.<br><br>The administrator and/or the DON will review and present the findings of the Medication Transcription Audit tool and the Medication Pass Audit Tool to the Executive Quality Improvement (QI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.<br><br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |