STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment 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).	F 580		9/14/18

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

Electronically Signed | 09/11/2018

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F 580	Continued From page 1 §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interviews the facility failed to notify the physician/Nurse Practitioner when a resident's scheduled dialysis treatment conflicted with administering medications resulting in multiple missed doses including 6 doses of an antiplatelet and 10 doses of insulin for 1 of 1 resident reviewed for notification (Resident #296). Findings included: Resident #296 was admitted to the facility on 08/07/18 with diagnoses which included end stage renal disease, diabetes mellitus (excessive amounts of sugar in the blood) with chronic renal disease, and dependence on renal dialysis (a process used to cleanse the blood of impurities). Review of the entry Minimum Data Set dated 08/07/18 revealed Resident #296 was admitted to the facility after an acute hospitalization. The interim/baseline care plan dated 08/07/18 identified Resident #296 received dialysis through a central vein catheter. A left upper arm fistula (a connection between an artery and vein used to receive dialysis treatment) was also identified	F 580	The facility nurse practitioner for Resident #296 was notified on 8/22/18 by the facility Director of Nursing that two medications were missed numerous times due to conflictions with the resident's out of facility dialysis schedule. The facility nurse practitioner and Director of Nursing on 8/22/18 reviewed Resident #296 medication regimen and adjusted medication administration times to prevent missed doses due to the Resident #296 being out of the facility at dialysis. The Director of Nursing on 8/22/18 conducted an audit to identify any other residents that were receiving dialysis or other treatments on a set schedule requiring the resident to be out of the facility for extended lengths of time. The Director of Nursing identified one other resident that is out of facility related to dialysis treatment. The identified resident had not missed any doses and the medication regimen did not require any changes. Additionally, the Director of Nursing did extend the audit to include 100% of current census to evaluate for	

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F 580	Continued From page 2	F 580		

along with poor controlled diabetes.

The hospital discharge summary dated 08/07/18 read in part Resident #296 presented to the emergency room on 07/31/18 with a blood sugar level greater than 700 and left upper arm swelling. The active medications upon discharge on 08/07/18 included fast acting insulin (a medication used to control high blood sugar levels) and clopidogrel (an antiplatelet medication which thins the blood to prevent blood clots).

A review of the physician progress note dated 08/14/18 identified Resident #296's history of end stage renal failure with continued dialysis treatments and type 2 diabetes mellitus. The progress note revealed the high blood sugar levels were controlled upon admission to the facility and the plan was to monitor and adjust insulin as needed.

Review of the active physician orders included:

a. clopidogrel bisulfate give 1 tablet by mouth one time a day for a blood thinner. The medication was started on 08/08/17.

b. Inject 14 units of insulin aspart before meals and inject insulin aspart per sliding scale perimeters before meals and at bedtime for diabetes mellitus. Administer 12 units of insulin aspart and recheck blood sugar levels in 1 hour and notify the Medical Doctor for blood sugar readings greater than 450. The medication was started on 08/07/18.

A review of the August 2018 monthly medication administration record revealed nurses documented Resident #296 was out of the facility

any missed medication administration within the prior 30 days. The 100% audit was completed 9/4/18.

The Director of Nursing began education on 8/23/18 to licensed nurses on facility expectation of physician notification for missed administration of medications. Education was continued and completed by the Staff Development Coordinator on 9/7/18. Any new hired nurses will be provided education during orientation on the facility expectation of physician notification for missed administration of medications.

The Director of Nursing, and/or designee inclusive of the Quality Assurance Nurse, MDS Nurse, and Staff Development Coordinator will review the Medication Administration Records for those identified residents who are out of the facility frequently related to dialysis treatment and/or other procedures requiring the resident to be out of the facility frequently and for extended lengths of time. The audits will occur 5 times weekly for a period of 4 weeks, 2 times weekly for a period of 4 weeks, 1 time weekly for 4 weeks, biweekly for 4 weeks, and monthly for 3 months. The findings will be reviewed weekly by the Director of Nursing and any additional education or monitoring will be implemented as necessary dependent on the findings of the audit.

The Director of Nursing is responsible for implementing this Plan of Correction and

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F 580	Continued From page 3 and did not receive antiplatelet medication (Clopidogrel) scheduled daily on the following dates: 08/09 (Nurse #1), 08/11 (Nurse #3), 08/14 (Nurse #1), 08/16 (Nurse #4), 08/18 (Nurse #4), and 08/21 (Nurse #1). Nurse #1 documented Resident #296 was out of the facility and did not receive insulin aspart injection on 08/09 at 7:30 AM. On 08/11 Nurse #3 documented Resident #296 was out of the facility and did not receive insulin aspart doses scheduled for 7:30 AM and 11:00 AM. On 08/14 Nurse #1 documented Resident #296 was out of the facility and did not receive insulin aspart scheduled at 7:30 AM. On 08/16 and 08/18 Nurse #4 documented Resident #296 was out of the facility and did not receive insulin aspart scheduled at 7:30 AM and 11:00 AM. On 08/21 Nurse #1 documented Resident #296 was out of the facility and did not receive insulin aspart injections scheduled for 7:30 AM and 11:00 AM. The highest blood sugar reading on the days Resident #296 had missed insulin was 434 on 08/21 at 4:00 PM. During an interview on 08/22/18 at 2:26 PM, Nurse #1 explained Resident #296 received dialysis treatments on days the antiplatelet was not administered. She explained the medication was scheduled at 8:00 AM and the resident left for dialysis around 5:45 AM and returned to the facility at approximately 1:00 PM. She explained Resident #296 was scheduled to receive insulin aspart at 7:30 AM before breakfast and at 11:00 AM before lunch along with a sliding scale insulin dose based on perimeters of the blood glucose readings. Nurse #1 revealed the reason Resident #296 missed 10 doses of insulin aspart were due to the conflict between dialysis treatment and the time insulin injections were scheduled. The treatments were scheduled early in the morning	F 580	reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	

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F 580	Continued From page 4	F 580		

on Tuesday, Thursday, and Saturday. Resident #296 would leave the facility at approximately 5:45 AM missing the breakfast dose and at times didn't return to receive the lunch dose of insulin causing the medication to be missed twice on some days. Nurse #1 revealed if breakfast and lunch doses were missed the next scheduled dose would be at 4:00 PM. She explained when a resident missed scheduled medications for 2-3 days she would inform the Medical Doctor/FNP. She indicated she could not review the medication administration record for previous days and could only review the day she was working and wasn't aware Resident #296 had missed several days/doses of the antiplatelet and insulin aspart injections.

During an interview on 08/22/18 at 3:21 PM, the FNP confirmed she wasn't aware Resident #296 missed multiple doses of medications. She identified the antiplatelet medication as the most important medication that should have been administered and explained the reason was due to a history of blood vessel occlusion. She considered the fact an antiplatelet medication was not administered as ordered to be a significant error and would've have liked to have been informed when multiple doses were missed. The FNP confirmed no harm had occurred and explained the process used during dialysis treatments included an antiplatelet medication and the fact no concerns had been identified by the dialysis center related to gaining access to the central line catheter used to provide the treatments. The FNP revealed the insulin aspart was used to treat Resident #296's diabetes and history of high blood sugar readings. She would have adjusted the insulin dose if she had been informed of the blood sugar readings and missed

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F 580	Continued From page 5 doses. The FNP confirmed she would've have liked to have been informed when multiple doses of medications were missed. During an interview on 08/23/18 at 9:57 AM, the Director of Nursing (DON) revealed it was her expectation when medications were not administered, nurses would contact the Medical Doctor/FNP. The DON expected the nurses to ask for a physician's order to change the administration times to prevent medications from being missed. The DON confirmed on 08/23/18, the physician/FNP had been made aware of and an order was provided to change the administrations times for Resident #296 morning medications to ensure they were received on the days she received dialysis treatments. During an interview conducted on 08/22/18 at 4:20 PM, the Administrator revealed it was her expectation nurses would notify the Medical Doctor/FNP when residents' dialysis schedule conflicted with medication administration times causing multiple medications not to be administered. She expected the administration times would be adjusted to ensure medications were not missed.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		9/14/18

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F 584	Continued From page 6 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain cleanliness for 1 of 2 residents' wheelchairs observed (Resident #31). The findings included:	F 584	The wheelchair for resident #31 was identified to have visible soiling related to failure of staff to adhere to facility procedure for routine equipment cleaning and monitoring for as needed cleaning. The wheelchair for Resident #31,	

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F 584	Continued From page 7 On 08/20/18 at 3:24 PM, Resident #31 was observed lying in bed with her wheelchair placed next to the bed. The wheelchair was observed with a white smudge the size of a walnut on the right padded armrest, crumbs in the seam of the seat cushion, and food particles stuck on the side of the wheelchair between the left armrest and the seat cushion. An additional observation on 08/23/18 at 10:37 AM revealed the white smudge was still on the padded armrest. The resident was sitting in the wheelchair so the cushion and plate under the armrest could not be observed. At this time, the spokes of the wheels on both side of the wheelchair were observed with dust that was easily removed by wiping making a little pile of dust. An interview with Nursing Assistant (NA) #2 on 08/23/18 at 10:19 AM revealed the night shift had a list of wheelchairs that should be cleaned each night. The NA added during the day, the NAs were supposed to wipe debris from the chairs. An interview with the Director of Nursing (DON) on 08/23/18 at 10:59 AM revealed third shift staff had a schedule of so many wheelchairs that were supposed to be cleaned each night. The DON explained night shift staffing had recently been unstable. Ensuring that this task was done had fallen through the cracks.	F 584	inclusive of the armrest, wheels, spokes, and seat cushion was cleaned on 8/23/18 by the Director of Nursing. An audit of the cleanliness of all resident wheelchairs, inclusive of the armrests, wheels, spokes, and seat cushions, began on 8/24/18 and was completed 8/28/18. The audit was completed by the Quality Assurance nurse, Director of Nursing, and MDS nurse. Any wheelchairs identified to be soiled or required cleaning to maintain a comfortable and homelike environment was thoroughly cleaned. Certified Nurse Aides were provided education by the Staff Development Coordinator beginning 9/4/18 and completing 9/7/18 on the facility procedure and expectation for monitoring and maintaining resident wheelchairs and/or other adaptive mobility devices in a clean, comfortable, and homelike manner. The Director of Nursing and\or designee inclusive of the Staff Development Nurse, Quality Assurance Nurse, or MDS Nurse, will audit five wheelchairs daily five times per week for four weeks, 5 wheelchairs 2 times weekly for a period of 4 weeks, 5 wheelchairs 1 time weekly for 4 weeks, 5 wheelchairs biweekly for 4 weeks, and 5 wheelchairs monthly for 3 months to ensure proper cleanliness. The findings will be reviewed weekly by the Administrator and any additional education or monitoring will be implemented as necessary dependent on the findings of the audit.	

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F 584	Continued From page 8	F 584	The Director of Nursing is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 6 residents reviewed for MDS medication assessments (Residents #54 and #59).	F 641	The assessments for Resident #59 and Resident #54 were identified to have coding inaccuracies for injections due to the failure of the MDS department to thoroughly review the medication administration records and accurately	9/14/18

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F 641	Continued From page 9 1. Resident #54 was admitted to the facility on 01/27/17 with diagnoses including but not limited to diabetes. Review of the quarterly Minimum Data Set (MDS) dated 07/18/18 revealed Resident #54 revealed 1 injection in the 7-day lookback and the 1 injection received was identified as insulin. Review of the Medication Administration Record (MAR) for July 2018 revealed Resident #54 had received daily insulin injections during the 7-day lookback period. During an interview on 08/22/18 at 1:30 PM, the MDS Coordinator reviewed and verified the MDS had been coded incorrectly and stated her expectations were for the MDS coding to be correct. During an interview on 08/23/18 at 1:36 PM, the Director of Nursing (DON) stated her expectations were for the MDS to be coded correctly. 2. Resident #59 was admitted to the facility 07/07/18 with diagnoses which included diabetes mellitus and cerebral infarction. A review of the most current admission Minimum Data Set (MDS) dated 07/14/18 under section N labeled medications indicated Resident #59 received 5 injections during the 7-day look back period of the assessment. Section N also indicated 5 doses of an anticoagulant (a medication used to thin the blood) was administered. A review of the July 2018 Medication	F 641	document the total number of injections in section N0300. The completed MDS assessments for Resident #59 and Resident #54 were corrected and modified to represent the accurate number of injections the residents received during the assessment reference period. The modified assessments were submitted on 8/22/18. The Director of Nursing and Regional Director of Clinical Reimbursement conducted an audit of all assessments completed within the prior 30 days to ensure the accurate documentation of injections administered in correlation with the medication administration record. Audit was completed on 9/4/18. One assessment identified with a correction and modification completed and submitted. Education was provided by the Regional Director of Clinical Reimbursement on 8/28/18 to the MDS Coordinator and MDS Assistant on the accurate completion of Section N0300. The Director of Nursing will audit 100% of completed MDS assessments for four weeks, 50% of completed MDS assessments for four weeks, 25% of completed MDS assessments for four weeks, and 10% of completed assessments monthly for three months. The MDS assessment will be reviewed for accuracy of coding for section N0300 in comparison the Medication Administration Record. The findings will be reviewed weekly by the Administrator and any additional	

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F 641	Continued From page 10 Administration Record (MAR) revealed 6 injections of medications were administered. The documented injections received were from 07/09, 07/10, 07/11, 07/12, 07/13, and 07/14 and included an anticoagulant (a medication used to thin the blood) and a test for tuberculosis (infectious lung disease) (TB) injection. The MAR revealed an anticoagulant was administered for 6 days during the look back period of the assessment from 07/09, 07/10, 07/11, 07/12, 07/13, and 07/14. During an interview conducted on 08/22/18 at 1:40 PM, the MDS Coordinator/RN explained she recorded 5 injections were given during the 7-day look back period, but after she reviewed the July MAR confirmed 5 anticoagulant and 1 TB was administered equaling 6 injections. She overlooked the TB injection. After reviewing the anticoagulant medications administered in July, she documented 5 doses were administered. She confirmed 6 doses were administered and she missed 1 dose. She explained a modification would be done to reflect the correct number of injections received were 6 and correct number of anticoagulant doses administered were 6. During an interview conducted on 08/23/18 at 10:05 AM, the Director of Nursing revealed her expectations were for the MDS to be correctly coded.	F 641	education or monitoring will be implemented as necessary dependent on the findings of the audit. The Director of Nursing is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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;	F 677		9/14/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide nail care to 1 of 5 sampled residents who were dependent on staff for assistance with activities of daily livings (ADLs) (Resident #32). The finding included: Resident #32 was admitted to the facility on 04/25/18 with diagnoses which included Alzheimer's' disease, dementia, diabetes mellitus (DM), and depression. A quarterly Minimum Data Set (MDS) dated 07/01/18 indicated the Resident's cognition was moderately impaired and required extensive staff assistance for most of his ADLs included bathing and personal hygiene. The MDS indicated Resident #32 with no history of refusal of care. A care plan dated 07/23/18 described Resident #32 with ADLs self-care performance deficit related to generalize weakness. The care plan specified the Resident would improve current level of function in ADLs with goal of returning home. Interventions included extensive assist of staff regarding bathing and personal hygiene, checked nail length and trimmed and cleaned on bath day and as necessary. An observation on 08/20/18 at 11:02 AM revealed Resident #32's fingernails extended 3-4 millimeter (MM) beyond her fingertips. However, all 5 fingernails on each hand were observed without brownish substances under each nail. An additional observations on 08/21/18 at 03:06	F 677	The fingernails for Resident #32 were identified to be at a length in which trimming would be appropriate due to staff failure to initiate trimming during the assigned shower schedule as a result of nurse aides not having a clear understanding of the facility expectation of an acceptable length for fingernails when the resident does not indicate a preference. The fingernails for Resident #32 were trimmed by the Licensed Practical Nurse on 8/22/18. An audit of all residents' nails was conducted by the Director of Nursing and Quality Assurance Nurse on 8/22/18. Nails were trimmed if necessary by nursing staff on 8/22/18. Education was provided to Certified Nurse Aides by the Staff Development Nurse beginning on 9/4/18 and completing on 9/7/18 on the facility procedure and expectation for maintaining the proper length of dependent resident fingernails. Certified Nurse Aides were provided education to ensure nails are cleaned and trimmed on shower days and as needed. Director of Nursing and\or designee inclusive of the Staff Development Nurse and Quality Assurance Nurse, will audit five residents daily five times per week for four weeks, 5 residents 2 times weekly for a period of 4 weeks, 5 residents 1 time weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 3 months to ensure proper nail length. The	

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F 677	Continued From page 12 PM and 08/22/18 at 03:10 PM revealed the fingernails remained untrimmed. No brownish substances were observed under each nail. In an interview conducted on 08/22/18 at 03:10 PM, Resident #32 stated he was unable to recall when his fingernails were last trimmed. He would like to have his fingernails trimmed in a timely manner. Normally he did not have to request for nail care, the nurse would check and trim his fingernails as needed. In an interview conducted on 08/22/18 at 03:27 PM, Nurse Aide (NA) #3 stated he had provided shower to Resident #32 on 08/21/18. He checked residents' skin conditions included fingernail during the shower. He was aware of Resident #32's fingernails were extended about 3-4 MM beyond the fingertips. However, he stated any residents' fingernails that were less than ¼ of an inch (about 6.35 MM) would not be a concern to him. That was why he did not report Resident #32's fingernail's condition to the nurse. He added Resident #32 was a diabetic and his fingernails had to be trimmed by a nurse. An observation was conducted with Nurse #2 on 08/22/18 at 03:40 PM. She stated Resident #32's fingernails that were about 3-4 MM extended beyond the fingertips needed to be trimmed immediately. She attributed the incident as a lack of communication between nurses and NAs and her carelessness when she provided care for Resident #32. She added Resident #32 did not have a history of refusal of care. An interview was conducted with the Director of Nursing (DON) on 08/23/18 at 11:04 AM. The DON stated it was not a facility policy to defer	F 677	findings will be reviewed weekly by the Administrator and any additional education or monitoring will be implemented as necessary dependent on the findings of the audit. The Director of Nursing is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	

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F 677	Continued From page 13 residents' fingernail care until they were ¼ of an inch extended beyond fingertips. It was her expectation for all the resident to receive proper nail care as ordered in a timely manner.	F 677		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, and physician interviews the facility failed to prevent a significant medication error by failing to administer 6 doses of an antiplatelet medication for 1 of 1 resident reviewed for dialysis (Resident #296). Findings included: A review of the hospital history and physical report dated 07/31/18 for Resident #296 described a procedure performed on 06/22/18. The procedure was to widen a central vein catheter using stents (a plastic or metal tube inserted into a blocked passageway to keep open and restore blood flow) had been successful. The hospital discharge instructions dated 08/07/18 included a list of medications Resident #296 was scheduled to receive. Clopidogrel (an antiplatelet medication which thins the blood to prevent blood clots) was to be administered every 24 hours. Resident #296 was admitted to the facility on 08/07/18 with diagnoses which included end	F 760	The facility nurse practitioner for Resident #296 was notified on 8/22/18 by the facility Director of Nursing that one significant medication was missed for six doses due to conflictions with the resident's out of facility dialysis schedule. The facility nurse practitioner and Director of Nursing on 8/22/18 reviewed Resident #296 medication regimen and adjusted medication administration times to prevent missed doses due to the Resident #296 being out of the facility at dialysis. The Director of Nursing on 8/22/18 conducted an audit to identify any other residents that were receiving dialysis or other treatments on a set schedule requiring the resident to be out of the facility for extended lengths of time. The Director of Nursing identified one other resident that is out of facility related to dialysis treatment. The identified resident had not missed any doses and the medication regimen did not require any changes. Additionally, the Director of Nursing did extend the audit to include	9/14/18

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F 760	Continued From page 14 stage renal disease, diabetes mellitus with chronic renal disease, and dependence on renal dialysis (a process used to cleanse the blood). Review of the entry Minimum Data Set dated 08/07/18 revealed Resident #296 was admitted to the facility after an acute hospitalization. The interim/baseline care plan dated 08/07/18 identified Resident #296 received dialysis through a central vein catheter. A left upper arm fistula (a connection between an artery and vein used to receive dialysis treatment) was also identified. Review of the facility physician orders of 08/07/18 for Resident #1 revealed 75 milligrams of clopidogrel was to be given one time a day and was used for a blood thinner. The medication was scheduled to start on 08/08/18. A review of the August 2018 monthly medication administration record revealed nurses documented Resident #296 was out of the facility and did not receive medications scheduled for 8:00 AM including the anticoagulant medication (Clopidogrel) that was scheduled daily on the following dates: 08/09 (Nurse #1), 08/11 (Nurse #3), 08/14 (Nurse #1), 08/16 (Nurse #4), 08/18 (Nurse#4), and 08/21 (Nurse #1). During an interview conducted on 08/22/18 at 9:28 AM, Resident #296 explained dialysis treatments were scheduled three times a week and with each visit the facility and the dialysis center communicated using a notebook to document any concerns and outcomes prior to and after each treatment. Resident #296 confirmed a central vein catheter in the right	F 760	100% of current census to evaluate for any missed medication administration within the prior 30 days. The 100% audit was completed 9/4/18. The Director of Nursing began education on 8/23/18 to licensed nurses on facility expectation of physician notification for missed administration of medications. Education was continued and completed by the Staff Development Coordinator on 9/7/18. Any new hired nurses will be provided education during orientation on the facility expectation of physician notification for missed administration of medications. The Director of Nursing, and/or designee inclusive of the Quality Assurance Nurse, MDS Nurse, and Staff Development Coordinator will review the Medication Administration Records for those identified residents who are out of the facility frequently related to dialysis treatment and/or other procedures requiring the resident to be out of the facility frequently and for extended lengths of time. The audits will occur 5 times weekly for a period of 4 weeks, 2 times weekly for a period of 4 weeks, 1 time weekly for 4 weeks, biweekly for 4 weeks, and monthly for 3 months. The findings will be reviewed weekly by the Director of Nursing and any additional education or monitoring will be implemented as necessary dependent on the findings of the audit. The Director of Nursing is responsible for	

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F 760	Continued From page 15 upper chest was accessed to provide treatments and denied any problems had occurred with receiving dialysis. Resident #296 explained feeling weak after dialysis treatments, and that was normal, and denied not feeling well. During an interview conducted on 08/22/18 at 2:26 PM, Nurse #1, who worked 7AM to 7 PM explained she documented Resident #296 was out of the facility on days the blood thinner wasn ' t administered. Nurse #1 revealed the medication was scheduled at 8:00 AM and Resident #296 would leave the facility at approximately 5:45 AM for dialysis treatment causing medications to be missed. Nurse #1 stated she had not notified the physician that Resident #296 had not received her 8:00 AM medications on the mornings she went to dialysis. During an interview on 08/22/18 at 3:21 PM, the Family Nurse Practitioner (FNP) revealed she wasn ' t aware Resident #296 had missed multiple doses of medications when out of the facility at dialysis treatments. She identified the antiplatelet medication as the most important medication that should have been administered and explained the reason was due to a history of occlusion and a stenting procedure. She considered the fact an antiplatelet medication was not administered as ordered to be a significant error and would've have liked to have been informed when multiple doses were missed. The FNP confirmed no harm had occurred and explained the process used during dialysis treatments included an anticoagulant medication and the fact no concerns had been identified by the dialysis center related to gaining access to the central line catheter used to provide the treatments.	F 760	implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	

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F 760	Continued From page 16 During an interview on 08/23/18 at 9:57 AM, the Director of Nursing (DON) revealed it was her expectation when medications were not administered, nurses would contact the Medical Doctor/FNP. The DON expected the nurses to ask for a physician ' s order to change the administration times to prevent medications from being missed. The DON confirmed on 08/23/18, the physician/FNP had been made aware of and an order was provided to change the administrations times for Resident #296 morning medications to ensure they were received on the days she received dialysis treatments. During an interview conducted on 08/22/18 at 4:20 PM, the Administrator revealed it was her expectation nurses would notify the Medical Doctor/FNP when residents ' dialysis schedule conflicted with medication administration times causing multiple medications not to be administered. She expected the administration times would be adjusted to ensure medications were not missed.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/14/18

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F 880	Continued From page 17	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(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 880	Continued From page 18 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 sanitize hands after touching residents and staff member's face and hair while assisting residents with meal service in the assisted dining room during 1 of 1 dining observation. The findings included: Review of a facility policy dated June 2013 entitled Infection Control Meal Service specified employees must wash and/or use hand sanitizer after touching anything other than items on the meal tray. On 08/20/18 at 11:56 AM, Nursing Assistant (NA) #1 was observed delivering meal trays from a tray cart in the dining room for residents that required assistance with eating. Residents #2 and #23 were seated in their geri chair and wheelchair around a curved table. On 08/20/18 at 11:57 PM as NA #1 delivered a meal tray to Resident #2, she patted the resident on his left shoulder. The	F 880	Nurse Aide #1 was identified during the meal service to not adhere to the facility expectation for infection prevention during the dining service as exhibited by not sanitizing hands after touching face, hair, and multiple residents before continuing with dining assistance. The facility expectations are reviewed during new hire education, annually thereafter, and as needed. Nurse Aide #1 was reeducated on 8/20/18 on facility procedure and expectation for providing services in a manner that will maintain an effective infection prevention and control program designed to provide a safe, sanitary and comfortable environment as it relates to assisting residents with dining services. Nurse Aide #1 was provided education on 8/20/18 by the Director of Nursing to sanitize hands after touching residents, self, and/or any items other than the tray. Education was provided to Certified Nurse	

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F 880	Continued From page 19 NA did not sanitize her hands before she delivered and set up a meal tray for Resident #23. As she bent over to get silver ware out of a paper wrapper and remove the cover from a plate of food, NA #1's long hair which was hanging down on both sides of her face was observed brushing the dinner table and the top of the cover over the plate of food. While she set up trays for both residents, NA #1 was observed using her left hand to flip the hair hanging down on the left side of her face to her back. She continued setting up the residents' meal trays without sanitizing her hands. NA #1 sat down on the opposite side of the curved table and still had not sanitized her hands. As NA #1 reached across the table using her left hand to provide a spoonful of food to Resident #2, the hair hanging down by the right side of her face was observed brushing the dining table. She was observed again using her left hand to flip the hair on the left side of her face toward her back. NA #1 placed her left hand on her left cheek and mouth as she reached across the table with her right hand to provide a spoonful of food to Resident #23. The hair on the right side of her face again brushed across the table. NA #1 was observed reaching under the table with her right hand and tapped Resident #23's leg while calling his name in order to wake him. She continued to assist Resident #2 and Resident #23 while intermittently placing a hand to her face and did not utilize hand sanitizer. She was further observed multiple times flipping the hair on the left side of face to her back. During an interview with NA #1 at 12:13 PM on 08/20/18 she was asked why she continued to touch her face and her hair while assisting residents with their meal without sanitizing her hands, she replied she did not realize she was	F 880	Aides and Administrative staff who assist with the meal service beginning 8/20/18 and completing 9/7/18 by the Staff Development Coordinator on the facility policy for Infection Control during Meal Service. Director of Nursing and\or designee inclusive of the Staff Development Nurse, Quality Assurance Nurse, and Administrator will audit five employees daily five times per week for four weeks, 5 employees 2 times weekly for a period of 4 weeks, 5 employees 1 time weekly for 4 weeks, 5 employees biweekly for 4 weeks, and 5 employees monthly for 3 months to ensure that proper infection prevention is utilized during the meal service. The findings will be reviewed weekly by the Administrator and any additional education or monitoring will be implemented as necessary dependent on the findings of the audit. The Director of Nursing is responsible for implementing this Plan of Correction and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The QAPI committee consists of, but not limited to, the Director of Nursing, Administrator, Quality Assurance nurse, MDS Director, Staff Development Coordinator, Social Worker, Activities Director, Dietary Manger, Maintenance Director, Medical Records, Medical Director, and Pharmacy Consultant. The audits will be reviewed monthly and recommendations for changes to the plan of correction will	

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F 880	Continued From page 20 touching her face or allowing her hair to brush the table. NA #1 offered no other explanation. She did ask another staff member in the room for hand sanitizer and a hair tie and stopped assisting the residents until she obtained and used both. At 12:18 PM on 08/20/18, the Director of Nursing (DON) was informed of NA #1's actions while assisting Residents #2 and #23 with the lunch meal. The DON stated all facility NAs had been taught not to touch their hair or face while assisting residents with meals and to use hand sanitizer if touching anything other than meal tray items. On 08/23/18 at 11:07 AM, the DON stated staff assisting residents with eating should not touch the residents or put their hands on their face. She added she expected hair to be kept in a manner so that it did brush table tops or have an opportunity of coming in contact with residents' food. The DON added inservices to NAs regarding this practice were initiated on 08/20/18.	F 880	occur if the facility is not maintaining compliance with regulatory requirements. The plan of correction can be changed to include additional education and monitoring to obtain and maintain substantial compliance. Date of Compliance: September 14, 2018	