STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 10/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

(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 000	INITIAL COMMENTS A complaint investigation (Event ID #J78Q11) was conducted on 10/09/18 through 10/12/18. Immediate jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity of J. The facility was notified on 10/18/18 of additional Immediate Jeopardy identified after management quality review: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.12 at tag F607 at a scope and severity of J. CFR 483.45 at tag F760 at a scope and severity of J. CFR 483.70 at tag F835 at a scope and severity of J. Tag F684, F600, F607, F760 constituted substandard quality of care. An extended survey was completed on 10/23/18. 11/20/18 Changes were made to the CMS 2567 BW	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		12/5/18

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

Electronically Signed | 11/16/2018

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to have a privacy cover on the urinary catheter bag for 1 of 3 residents reviewed for urinary catheters	F 550	Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that	

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F 550	Continued From page 2 (Resident #14). The findings included: Resident #14 was admitted to the facility on 06/16/15 and most recently on 09/21/18 with diagnoses which included: dementia without behaviors, hypertension, coronary artery disease, urinary retention, and benign prostatic hyperplasia with lower urinary tract symptoms. The admission Minimum Data Set (MDS) dated 09/28/18 revealed that Resident #14 was moderately cognitively impaired. Resident #14 was coded as requiring extensive assistance with most activities of daily living (ADL) including bathing. The MDS further revealed Resident #14 had an indwelling catheter during the reference period. An observation of Resident #14 on 10/09/18 at 7:45 am, revealed the resident was sitting in his wheelchair beside the bed in his room with his urinary catheter bag uncovered on wheelchair just below arm rest. Interview with NA #5 on 10/09/18 at 7:55 am revealed he usually placed urinary bags under the wheelchair and he was unaware of a cover for urinary bags. An observation was made of Resident #14 on 10/09/18 at 11:10 am in the facility front hallway with his urinary catheter bag under his wheelchair with urine visible and no privacy cover. An observation was made of Resident #14 on 10/09/18 at 12:03 pm exiting the therapy room with his urinary catheter bag under his wheelchair	F 550	the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Macon Valley Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F550 – Resident Rights How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/09/18 at 7:45 a.m., nursing assistant (NA) #5 hung the uncovered urinary catheter bag on Resident #15's wheelchair just below the arm rest. The urine was visible in the uncovered urinary catheter bag. NA #5 stated the NA was unaware the urinary catheter bag should have a privacy cover to promote resident dignity. On 10/09/18 after the dinner meal, Nurse #3 had Resident #15's urinary catheter bag changed so there was a privacy cover and urine was not visible.	

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F 550	Continued From page 3 with urine visible. An observation was made of Resident #14 on 10/09/18 at 12:42 pm in the facility dining room with his urinary catheter bag under wheelchair with urine visible. An interview on 10/09/18 at 4:45 pm with Nurse #3 stated urine should not be visible, and she will have bag changed. She further stated urinary bags should have privacy cover. An Interview with Director of Nursing (DON) 10/09/18 at 4:05 pm revealed a urinary catheter bag should have a blue privacy cover over it and urine should not be visible.	F 550	On 10/09/18, the director of nursing (DON) re-educated NA #5 regarding maintaining dignity of residents in relation to privacy covers on urinary catheter bags. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/09/18, the quality improvement (QI) nurse and DON audited urinary catheter bags to ensure privacy covers were used and/or urine was not visible in catheter bags. The audit revealed no other resident dignity issues related to visible urine in catheter bags hanging from wheelchairs. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/6/18, the staff facilitator (SF) initiated a 100% re-education of registered nurses (RNs), licensed practical nurses (LPNs), NAs, and all agency staff titled “Foley Catheter”. The re-education instructs staff “All drainage bags should have a privacy cover at all times” related to the importance of maintaining residents’ dignity. The in-service was completed 11/28/18. During the new employee orientation process the SF, quality improvement (QI) nurse, DON or administrator will provide resident rights – dignity and respect training. Beginning 11/6/18, the DON, QI nurse, SF, unit manager, activities director, social worker (SW), administrator,	

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F 550	Continued From page 4	F 550	manager on duty, and corporate consultant began administrative rounds to ensure urinary catheter bags have a privacy cover. The results of the administrative rounds is being documented the administrative rounds sheet. The administrative rounds, including monitoring for urinary catheter bag privacy covers, will be completed five (5) times weekly for four (4) weeks, then once weekly times eight (8) weeks, then once monthly for one month. How the facility plans to monitor its performance to make sure that solutions are sustained Beginning 11/7/18, the QI nurse will review the results of the audits with the monthly QI committee for four (4) months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The QI nurse will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) Committee for further recommendations and oversight.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §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	F 558		12/5/18

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F 558	Continued From page 5 other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and family and staff interview, the facility failed to maintain fluids within the reach of 3 of 15 sampled residents. (Residents #1, #4, and #13). The findings included: 1. Resident #1 was admitted to the facility on 07/09/18. His diagnoses included Parkinson Disease, diabetes, convulsions and dysphagia. The Minimum Data Set, an admission dated 07/16/18 coded him as having severely impaired cognitive skills, requiring extensive assistance with most activities of daily living including eating. The care plan initiated 07/16/18 for eating was for Resident #1 to have no choking or aspiration episodes. Interventions were to set up the tray for him at each meal and provide pureed and thickened liquids. Resident #1 was observed to feed himself very slowly during the breakfast meal on 10/09/18 and the noon meal on 10/10/18. Resident #1 was observed in bed with no liquids in reach on 10/09/18 at 6:53 AM and at 10:33 AM. There was a cooler located on the bedside table with a warm ice pack and warm pudding and no liquids. At 10:59 AM, a care giver assistant (GCA) #1 entered and filled the cooler with a new ice pack and plenty of nectar thick fluids. Resident #1 was not offered any fluids at this time. Fluids remained out of his reach on 10/09/18 at 11:28 AM, 12:06 PM, 12:24 PM, 1:08	F 558	F 558 – Reasonable Accommodations How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/9/18, geriatric care assistant (GCA) #1 filled the cooler with a new ice pack and nectar thick liquids. Resident #1 was not offered fluids. On 10/10/18, nurse assistant (NA) #4 revealed Resident #1 was becoming more independent. NA #4 never saw Resident #1 access anything from the cooler and was unable to open the cartons of thickened liquids. NA #4 waited for Resident #1 to ask for fluids. Beginning on 10/24/18, the unit manager and/or director of nursing (DON) ensured Resident #1 was offered thickened liquids during and in between meals. On 10/9/18, Resident #4 was able to feed himself breakfast independently in the main dining room. On 10/9/18, Resident #4 fed himself lunch in the dining room. On 10/9/18 the GCA filled the water pitcher but left the water pitcher out of reach. Beginning on 10/24/18, the unit manager, assigned department head, DON, and/or administrator ensured Resident #4's water pitcher was in reach. On 10/9/18, NA #1 removed Resident #13's tray and sippy cup of fluid and left the resident without fluids within reach. On 10/9/18, Resident #13 was observed	

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F 558	Continued From page 6 PM, at 3:02 PM, 4:41 PM, and again on 10/10/18 at 11:29 AM, at 11:58 AM and at 2:02 PM. An interview with Nurse Aide #4 on 10/10/18 at 2:02 PM revealed Resident #1 was becoming more independent. She stated she never saw him access anything from the cooler and that he was unable to open the cartons of thickened liquids. She further stated that she did not leave the fluids out as the thickened liquids would become gummy and attracted bugs and he often knocked them over. She stated she waited for Resident #1 to ask for fluids. The Director of Nursing stated during an interview on 10/10./18 at 6:33 PM that she expected water to be in reach for residents to access it. 2. Resident #4 was admitted to the facility on 03/30/18. His admission Minimum Data Set dated 04/06/18 coded him with severely impaired cognition, requiring set up and supervision for eating and extensive assistance for other activities of daily living skills. Resident #4 was observed feeding himself independently in the main dining room on 10/09/18 at 8:09 AM. After he was finished, he was brought back to his room at 8:37 AM he was left sitting in his broda chair in front of the television and his water pitcher and cup was on the overbed table across the room. He was observed with his fluids out of his reach on 10/09/18 at 9:17 AM, at 9:36 AM, 9:57 AM, 10:09 AM, and at 11:29 AM. Resident #4 fed himself lunch in the dining room at 12:21 PM. He was observed in bed with his fluids across the room on 10/09/18 at 3:01 PM and at 4:41 PM. After the care giver assistant (GCA) #1 filled the water	F 558	with a sippy up in her room on the over-the-bed table and pushed out of resident's reach. Beginning on 10/24/18, the unit manager, assigned department head, DON and/or administrator ensured Resident #13's tray and sippy cup of fluid were within reach. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/29/18, the staff facilitator (SF) initiated an education on liquids to include thickened liquids: Nectar and Honey Consistency must be within reach of the resident when placed at bedside. On 11/1/18, the DON performed a 100% audit on residents receiving thickened liquids to ensure their liquids were within reach. The audit identified residents with liquids out of reach. The director of nursing immediately placed the residents' thickened liquids within reach of the resident. On 11/1/18, the DON performed a 100% audit on residents receiving thickened liquids to ensure the resident(s) had the appropriate adaptive equipment needed to consume the beverage. The audit determined residents did have adaptive equipment for drinking liquids. On 11/1/18, the administrator approved the dietary manager and therapy manager to order additional adaptive equipment to	

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F 558	Continued From page 7 pitcher, the water pitcher and cup were left across the room out of Resident #4's reach. An interview with Nurse Aide #4 on 10/10/18 at 2:02 PM revealed Resident #4 needed a small cup to drink the water from. She further stated that sometimes when the GCAs bring the residents back from a meal in the dining room, they failed to ensure the fluids are in their reach. She stated there was not enough staff to keep up with all the residents' needs. The Director of Nursing stated during an interview on 10/10./18 at 6:33 PM that she expected water to be in reach for residents to access it. 3. Resident #13 was admitted to the facility on 03/10/16. The annual Minimum Data Set dated 09/12/18 coded her as requiring set up and supervision for eating. On 10/09/18 at 8:31 AM Nurse Aide (NA) #1 removed the tray and unfinished sippy cups of fluid and left the resident in bed without fluids in her reach. She was observed without fluids in her reach while in bed on 10/09/18 at 9:36 AM, 9:56 AM, and 10:09 AM. Resident #13 was observed on 10/09/18 at 10:55 AM in a recliner in her room without fluids in her reach. On 10/09/18 at 11:44 AM, family stated during an interview that Resident #13 needed a sippy cup or smaller plastic cup for her fluids because she can't handle the large water pitcher. Family further stated that family tried to take a sippy cup off the lunch tray and put it in a drawer so the resident would have one available. On 10/09/18 at 11:50 AM, Resident #13's room	F 558	ensure there was extra cups with lids available. The order of extra specialty cups and lids was received. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/29/18, the staff facilitator (SF) initiated a 100% in-service on “Liquids to include Thickened Liquids Example: Nectar and Honey Consistency must be within reach of the resident when placed at bedside.” The in-service was for registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), geriatric care assistants (GCAs), and agency staff. No RN, LPN, NA, GCA, or agency staff were allowed to work after 11/19/18 until the in-service was completed. Starting 10/29/18, the in-service will be included with orientation for all newly hired RN, LPN, NA, GCA, and agency staff. On 11/8/18, the DON completed a 100% audit of residents on thickened liquids to ensure the residents’ drinks were cold, in a cooler at the bedside within reach, and had a cold ice pack. No negative findings were noted upon the audit. On 11/8/18, the DON completed a 100% audit of residents with adaptive equipment to ensure all appropriate equipment was readily accessible with extra supplies on hand so residents can drink their liquids.	

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F 558	Continued From page 8 was observed to have no sippy cup in sight. On 10/09/18 at 3:00 Pm and at 4:47 PM fluids and a sippy cup were observed in her room on the overbed table. The overbed table was pushed out of Resident #14's reach. An interview with Nurse Aide #4 on 10/10/18 at 2:02 PM revealed Resident #4 needed a small cup to drink the water from. She further stated that sometimes when the care giver assistants (GCAs) bring the residents back from a meal in the dining room, they failed to ensure the fluids are in their reach. She stated there was not enough staff to keep up with all the residents' needs. The Director of Nursing stated during an interview on 10/10./18 at 6:33 PM that she expected water to be in reach for residents to access it.	F 558	How the facility plans to monitor its performance to make sure that solutions are sustained: Starting 11/26/18, the DON initiated the Thickened Liquid audit tool. The DON, unit manager, and quality improvement nurse (QI) will monitor the residents on thicken liquids using the thickened liquids audit tool five times per week for four weeks, then weekly for four weeks, then monthly for four months. Beginning 11/26/18, the QI nurse will review the results of the audits with the monthly QI committee for four (4) months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The QI nurse will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) Committee for further recommendations and oversight.	
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		12/5/18

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F 561	Continued From page 9 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record reviews, the facility failed to honor the choices of 7 of 7 sampled residents to be showered or receive baths as often as they preferred which caused one resident state they felt miserable and dirty and another resident to state they were upset (Residents #1, #5, #10, #13, #16, #19 and #21). The findings included: 1. Resident #19 was admitted to the facility on 08/17/18. The admission Minimum Data Set dated 08/24/18 coded him with having moderate cognitive impairment, scoring a 12 out of 15 on the Brief Interview for Mental Status. He was coded to need extensive assistance with most activities of	F 561	F561 Self-Determination How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/09/18 at 7:45 am, nursing assistant (NA) #1 assisted Resident #21 with a bed bath. On 10/12/18, the NA assisted Resident #1 with a shower as requested by the family. On 10/22/18, the NA assisted Resident #5 with a shower as requested by the resident. On 10/15/18, the NA assisted Resident #10 with a shower as requested by the resident. On 10/12/18, the NA assisted Resident	

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F 561	Continued From page 10 daily living including bathing. During an interview with Resident #19, he stated that he had not received a shower in the entire time he was at the facility. He further stated he was offered a shower twice and waited for staff to get him but they never returned. He stated he had never refused a shower. He stated he would like a shower at least once a week and that he feels miserable and dirty. Review of the computer and paper documentation for Resident #19 revealed no evidence he was ever provided a shower. Interview with Nurse Aide #3 on 10/10/18 at 9:54 AM revealed that there is often no time to give showers on the hall so she does her best to wash residents up but not in the shower. She further stated there have been lots of complaints about showers being missed. Interview with Nurse Aide #6 on 10/10/18 at 10:29 AM revealed Resident #19 was independent with his own care. Nurse Aide #8 was interviewed on 10/10/18 at 12:52 PM. He stated he got information about resident needs and abilities via word of mouth or asking the resident. He further stated that he thought he was told Resident #19 did all care for himself. He stated that in the few weeks he has been at this facility, he was finding out that residents who reportedly could do for themselves really needed more assistance. Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing	F 561	#13 with a shower as requested by the family. On 10/16/18, the NA assisted Resident #16 with a shower as requested by the resident. On 10/18/18, the NA assisted Resident #19 with a shower as requested by the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/1/18, the DON audited shower documentation to determine if residents were getting showers as requested by the resident/family. The audit determined showers/bed baths were not being given as request by the resident/family. Over 50% of residents were not receiving showers/bed baths as often as the resident/family requested. On 11/2/18 through 11/7/18, the social worker and activities director talked with residents/families to determine what type of bathing was preferred, the frequency requested, and the time of day desired to be assisted with a shower/bed bath. The resident□s/family□s choices for bathing was documented on the Resident Preference Interview Tool. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/6/18, during the daily interdisciplinary team (IDT) meeting the unit manager and DON identified a barrier to the facility honoring the bathing choices of residents. The unit manager and DON	

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completed. She stated she has received a lot of complaints from families and residents about showers not being completed. The DON also stated that she expected the showers and bathing schedules to be followed.

2. Resident #5 was admitted to the facility on 06/05/17 with diagnoses of chronic obstructive pulmonary disease, respiratory failure and muscle weakness.

Review of the quarterly Minimum Data Set dated 08/13/18 revealed Resident #5 was cognitively intact and required limited assistance with bathing.

Review of the care plan dated 08/27/18 revealed Resident #5 required assistance to restore or maintain maximum function of self-sufficiency for bathing related to physical limitations and weakness. The goal was for Resident #5 to be neat, clean and odor free daily. The interventions included: set up help from staff for bathing, ensure hair was washed and nails manicured on bathing days.

Review of the 200 hall facility shower sheets revealed Resident #5 received four showers from 09/08/18 through 10/09/18 on 09/11/18, 09/18/18, 09/28/18, and 10/06/18. There were no refusals of showers noted on the shower sheets.

An interview conducted on 10/09/18 at 8:10 AM with Nurse Aide #5 (NA) revealed he was the only NA on the 200 Hall for the 7:00 AM to 3:00 PM shift. He stated there was no way to do showers, incontinence rounds, pass trays, assist with feeding residents and get residents dressed and out of bed for 28 residents when he was by

determined there were two different and conflicting shower schedules being referenced by the staff. On 11/6/18, the unit manager and DON clarified the one shower schedule for nursing staff to reference.
On 11/6/18, also during the IDT meeting, the administrator reviewed options for obtaining additional staff assistance in providing showers/bed baths. The facility administrator arranged for assistance from one outside staffing agency to ensure residents bathing choices are honored.
On 11/6/18, the staff facilitator (SF) initiated a 100% re-education of all staff titled Right to Make Choices. Also, the SF initiated a 100% re-education of all registered nurses (RNs), licensed practical nurses (LPNs), NAs and agency staff regarding following resident care plans/resident care guides and honoring resident bathing choices. The re-education instructs staff Residents should be allowed to have a bed bath or shower based on their choice related self-determination through support of resident choice. The in-services will be completed by 11/19/18. No staff were allowed to work until in-serviced. During the new employee orientation process the SF, quality improvement (QI) nurse, DON or administrator will provide resident Self-Determination training.
Beginning 11/6/18, the DON, QI nurse, SF, unit manager, activities director, social worker (SW), administrator, manager on duty, and corporate consultant began administrative rounds to

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himself on the hall. He stated showers didn't get done and rounds were usually only done once a day.

An interview conducted on 10/09/18 at 10:47 AM with Resident #5 revealed she was upset because she wasn't receiving two showers a week. She stated the facility was short staffed and they didn't have time to help her with her showers.

An interview conducted on 10/10/18 at 11:55 AM with NA #7 revealed she all halls and when she had to work the hall by herself she was not able to give showers. She stated she usually worked a hall by herself 3 to 4 days a week.

An interview conducted on 10/10/18 at 6:30 PM with the Director of Nursing revealed she was aware that some days there wasn't enough staff to give resident showers and she has had many complaints from families and residents regarding showers not being given. She further stated it was her expectation that shower schedules be followed.

3. Resident #21 was admitted to the facility on 08/21/18 and most recently on 09/10/18.

The admission Minimum Data Set dated 08/28/18 coded her as having moderately impaired cognition, scoring a 12 out of 15 on the Brief Interview for Mental Status. She was coded as requiring extensive assistance with most activities of daily living skills including bathing.

On 10/09/18 at 8:31 AM, a family member left Resident #21's room and was observed to ask Nurse Aide (NA) #1 to give Resident #21 a

ensure the facility is promoting and facilitating resident self-determination through support of resident choice, including honoring bathing choices. The results of the administrative rounds is being documented the administrative rounds sheet. The administrative rounds, including monitoring provision of showers/bed baths, will be completed five (5) times weekly for four (4) weeks, then once weekly times eight (8) weeks, then once monthly for one month.

How the facility plans to monitor its performance to make sure that solutions are sustained

Beginning 11/7/18, the QI nurse will review the results of the bathing audits with the monthly QI committee for four months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The QI nurse will present trends and QI committee recommendations to the quarterly quality assessment and assurance (QAA) Committee for further recommendations and oversight.

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shower. NA #1 stated he would check the shower schedule and give her a bath.

On 10/09/18 at 8:38 AM, Resident #21 stated during interview that she had been here approximately 2 months and only received 3 showers while in the facility.

During a follow up interview on 10/10/18 at 8:20 AM, Resident #21 stated that she preferred bed baths and would like a bed bath once a week. Resident #21 stated she was not receiving one bed bath a week and last Friday a family member complained about it. She stated again she wanted a bed bath once a week.

Review of the computer and handwritten documentation of showers/bathing provided revealed Resident #21 was bathed on 08/28/18, 09/03/18, refused on 09/29/18 and received a bed bath on 10/05/18. There was no other evidence provided to show Resident #21 had received more than 3 showers/baths since admission.

On 10/09/18 at 9:01 AM, NA #4 stated she usually worked the hall alone and was unable to get all the care completed. She did quick bed baths, washing the underarms and peri-area when getting residents up but was unable to give full baths/showers. She stated that she has told Administration about the care not being completed.

Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing completed. She stated she has received a lot of complaints from families and residents about

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showers not being completed. The DON also stated that she expected the showers and bathing schedules to be followed.

4. Resident #13 was admitted to the facility on 03/10/16.

The annual Minimum Data Set dated 09/12/18 coded her with severely impaired cognitive skills. She was coded as requiring extensive assistance with most activities of daily living skills including bathing. During the assessment period, the MDS coded that she had not had a bath/shower during the 7 day look back period.

On 10/09/18 at 11:30 AM, family was interviewed and stated today was her shower day. Upon follow up interview on 10/10/18 at 11:25 AM, family stated she preferred for Resident #13 to receive 2 showers per week.

On 10/09/18 at 9:01 AM, NA #4 stated she usually worked the hall alone and was unable to get all the care completed. She did quick bed baths, washing the underarms and peri-area when getting residents up but was unable to give full baths/showers. She stated that she has told Administration about the care not being completed.

Review of the computer and hand written shower documentation revealed she was scheduled to have showers on day shift Tuesdays and Fridays. Since 08/28/18 she missed her shower on 08/31/18, 09/07/18, 09/18/18, 09/21/18, 09/25/18, 09/28/18, and 10/05/18. There was no other evidence provided to support she had received showers on other days to make up for the missed showers.

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Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing completed. She stated she has received a lot of complaints from families and residents about showers not being completed. The DON also stated that she expected the showers and bathing schedules to be followed.

5. Resident #16 was admitted to the facility on 06/27/18.

Per review of the Minimum Data Set, an admission dated 07/04/18, Resident #16 had moderately impaired cognitive skills and required extensive assistance with bathing.

On 10/09/18 at 9:06 AM Resident #16 was observed asking Nurse Aide #4 for a shower this morning. NA #4 told the resident she would try to squeeze her in but she was on the floor by herself.

On 10/09/18 at 9:06 AM, Resident #16 stated in an interview that she only received a shower once every two weeks. She stated the staff keep putting her off when she asked for her shower. She stated she was supposed to be showered on Tuesday and Fridays.

Review of the computer and hand written shower records revealed she was not given a shower on 08/31/18, 09/07/18, on 09/11/18, 09/17/18, 09/21/18, 09/28/18, and 10/05/18. There was no documentation to support that she received showers as make up for these missed showers.

On 10/09/18 at 9:01 AM, NA #4 stated she

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usually worked the hall alone and was unable to get all the care completed. She did quick bed baths, washing the underarms and peri-area when getting residents up but was unable to give full baths/showers. She stated that she has told Administration about the care not being completed.

Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing completed. She stated she has received a lot of complaints from families and residents about showers not being completed. The DON also stated that she expected the showers and bathing schedules to be followed.

6. Resident #1 was admitted to the facility on 07/09/18.

The admission Minimum Data Set dated 07/16/18 coded him with severely impaired cognition, and requiring total assistance with bathing.

On 10/10/18 at 10:32 AM, a phone interview was conducted with family. Family stated at that time Resident #1 only received 1 shower per week and she wanted him to have 2 showers a week.

Review of the computer and handwritten shower records revealed he was given a shower on Monday 08/27/18 but none the rest of the week, on Monday 09/03/18 and none the rest of the week, once during the week of 9/10/18, none the week of 09/17/18, only once the week of 10/01/18.

On 10/09/18 at 9:01 AM, NA #4 stated she usually worked the hall alone and was unable to

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get all the care completed. She did quick bed baths, washing the underarms and peri-area when getting residents up but was unable to give full baths/showers. She stated that she has told Administration about the care not being completed.

Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing completed. She stated she has received a lot of complaints from families and residents about showers not being completed. The DON also stated that she expected the showers and bathing schedules to be followed.

7. Resident #10 was admitted to the facility on 08/03/17 with diagnoses of heart failure, non-Alzheimer's dementia, and muscle weakness.

Review of the significant change Minimum Data Set dated 07/17/18 revealed Resident #10 was moderately cognitively impaired and required total assistance with bathing.

Review of the care plan dated 08/01/18 revealed Resident #10 required assistance to restore or maintain maximum function of self-sufficiency for bathing related to cognitive impairment, impaired mobility, and physical limitations. The goal was for Resident #10 to be neat, clean, and odor free. The interventions included: bathing - one person physical assist/mechanical lift for transfer only. Encourage resident to participate in self-care as ability permits .Ensure hair is washed and nails are manicured on bathing day.

Review of the 300 hall facility shower sheets from

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F 561	Continued From page 18 09/08/18 through 10/09/18 revealed Resident #10 received a shower on 09/08/18, 09/17/18, and 09/27/18. There was no documentation of refusals or bed baths on the shower sheets. An interview conducted on 09/10/18 at 3:30 PM with Resident #10 revealed she was very upset because she wasn't getting her showers as scheduled. She stated she was supposed to have 2 showers a week and most weeks she received 1 or none. She stated they didn't have enough staff to give showers. An interview conducted on 10/10/18 at 2:10 PM with Nurse Aide #3 (NA) revealed she worked the 7:00 AM to 3:00 PM and the 3:00 PM to 11:00 PM shifts on the 300 hall. She stated she often worked the hall by herself and there was no way to do resident showers when she was on the hall by herself. An interview conducted on 10/10/18 at 11:55 AM with NA #7 revealed she worked all halls and when she had to work the hall by herself she was not able to give showers. She stated she usually worked a hall by herself 3 to 4 days a week. An interview conducted on 10/10/18 at 6:30 PM with the Director of Nursing revealed she was aware that some days there wasn't enough staff to give resident showers and she has had many complaints from families and residents regarding showers not being given. She further stated it was her expectation that shower schedules be followed.	F 561		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		12/5/18

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F 580	Continued From page 19 §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		

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F 580	Continued From page 20 §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 staff interviews, Nurse Practitioner interview, and record reviews, the facility failed to notify the physician of the missing insulin medication which caused the resident to be sent to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed for notification of change (Resident #2). The failure of the facility to notify the physician resulted in Resident #2 not receiving the medications he needed to prevent admission to the hospital for DKA. Immediate Jeopardy began on 09/11/18 when Nurse #4 did not notify the physician of the unavailability of the physician ordered insulin's which resulted in Resident #2 developing DKA. Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. Based on record review, staff, and Physician, the facility failed to communicate to the physician that	F 580	F 580 – Notification of Changes How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/12/18, Resident #2 experienced at FSBS reading of “HI.” The resident received two doses of 6 units of Regular insulin; however the resident’s FSBS reading would not drop below “HI.” Resident #2 was sent to the emergency room, where the resident was admitted with diabetic ketoacidosis, and placed on an insulin drip to lower his blood sugar. On 10/11/18 - 10/19/18, the director of nursing (DON) and quality improvement (QI) nurse audited Resident #20’s nursing progress notes and interviewed floor nurses regarding what was and what was not reported to the physician after Resident #20’s accident. Resident #20 no longer resides at the facility. How the facility will identify other residents	

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F 580	Continued From page 21 the resident had an unwitnessed fall and was on a blood thinner for one of three sampled residents reviewed for notification of change. The failure of the facility to comunicate an unwitnessed fall from bed to the floor and blood thinner use to the physician resulted in the high likelihood of serious injury or death (Resident #20). Immediate Jeopardy began on 09/22/18 for Resident # 20 when the facility failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner. Immediate Jeopardy was removed on 10/11/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: 1. Resident #2 was admitted to the facility on 9/11/18 with diagnoses which included: diabetes, heart disease, chronic kidney disease, and peripheral vascular disease. A review of the nurse practitioner (NP) progress note dated 09/12/18 indicated Resident #2 was seen on 09/12/18 after a capillary blood glucose (CBG) reading was 'HI'. The progress note indicated Resident #2 had also developed nausea and vomiting and he was clammy and anxious. An order was given by the NP to transfer the resident to the emergency department for possible diabetic ketoacidosis (DKA).	F 580	having the potential to be affected by the same deficient practice On 10/19/18, the DON and unit manager reviewed all facility residents receiving insulin to ensure insulin was available and had been administered as ordered. This review compared each resident's current insulin orders with the medication administration record (MAR) and the insulin available in the medication carts. On 10/22/18, the unit manager notified the medical director of the audit results including insulin omission for affected residents. No new orders were received. On 10/11/18 – 10/19/18, the DON and QI nurse audited 100% of nurse progress notes for all residents looking for any documented incidents/accidents. The audit revealed no other incidents accidents that had not been previously identified and the physician properly notified of an unwitnessed fall, including residents taking medications with blood thinning properties. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 10/11/18, the QI nurse initiated a 100% in-service with all registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), geriatric care assistants (GCAs) and agency staff. The in-service included the nurse must notify	

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F 580	Continued From page 22 Review of the nurse notes for 09/12/18 at 2:05 PM revealed the CBG taken at 7:30 AM read "HI". The nurse gave Resident #2 12 units of regular insulin per physician admission orders. The CBG was rechecked at 9:30 AM which read "HI". The note further revealed Resident #2 was vomiting and not feeling well and was seen by the NP who wrote an order for transfer to the emergency department for evaluation of possible DKA. Review of the September 2018 Medication Administration Record (MAR) revealed Resident #2 did not receive his physician ordered insulin's of 6 units on 09/11/18 at 5:00 PM and 10 units at 9:00 PM and his sliding scale insulin coverage at 4:30 PM for a CBG of 206 that required 2 units of coverage and 8:30 PM for a CBG of 240 that required 2 units of coverage. A record review of the September 2018 MAR further revealed Resident #2 received the physician ordered 6 units of regular insulin on 09/12/18 at 8:00 AM. Resident #2 also received 6 units of SSI regular insulin on 09/12/18 at 7:30 AM to cover a CBG of "HI". Review of the Blood Glucose Monitoring Sheet for 09/11/18 for Resident #2 revealed the following readings: 09/11/18 1:00 PM CBG 236 09/11/18 4:12 PM CBG 206 09/11/18 8:50 PM CBG 240 Per physician order and based on CBG reading of 206, Resident #2 should have received 2 units regular insulin on 09/11/18 at 4:30 PM.	F 580	the physician immediately of residents with unwitnessed falls that are on medications with blood thinning properties. Neurological checks must be started and the nurse must follow the facility's policy on neurological checks. If the resident is sent to the ER for evaluation and treatment due to an injury, the neurological checks must be restarted when the resident returns to the facility at the appropriate time. The DON must be notified of all falls with injuries, especially residents on blood thinners, within 2 hours of the incident to ensure the intervention is appropriate. On 10/19/18, the DON, QI nurse and staff facilitator (SF) began education with all registered nurses (RNs), licensed practical nurses (LPNs), and agency nurses licensed nurses on the importance of following insulin orders This education included: 1) the physician must be notified anytime the prescribed insulin is not available to administer as ordered, 2) the contents of the EDK are available for use if the medication ordered for the resident is not available, 3) insulin cannot be missed, the nurse must address immediately. No nurse is allowed to work until the education is completed. On 10/19/18, the DON, QI nurse and staff facilitator (SF) began education for 100% of RNs, LPNs, and agency nurses. The education covered the importance of communicating to the physician if a resident has an unwitnessed fall and if the resident is on a blood thinner.	

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F 580	Continued From page 23 Per physician order and based on CBG reading of 240, Resident #2 should have received 2 units regular insulin on 09/11/18 at 8:30 PM. An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his physician ordered insulin's on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. She further stated she did not give Resident #2 his Detemir insulin scheduled for 09/11/18 at 9:00 PM. She stated she did not look for the insulin and just did not give it. An interview with the NP on 10/10/18 at 10:00 AM revealed she was unaware Resident #2 had not received his insulin's the evening before he was sent to the hospital. Further interview with the NP revealed her expectation was for the facility nurse to contact the on-call physician if the insulin was not available. An interview with Nurse #4 on 10/10/18 at 10:45 AM revealed she did not contact the on-call physician to notify them of the unavailability of insulin or for further orders. During an interview with DON on 10/09/18 at 4:05 PM she revealed she expected facility staff to contact the physician for all missing medications. On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	F 580	How the facility plans to monitor its performance to make sure solutions are sustained Beginning 10/19/18, the DON, QI nurse, SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available and given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly and recorded on the Insulin Audit Sheet. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures. Beginning 10/19/18, the IDT (administrator, DON, QI nurse, minimum data set (MDS) nurse, treatment nurse, unit manager, weekend supervisor, and/or corporate consultant will review incident/accident reports, 24 hour reports, and nurse progress notes five (5) times weekly to ensure the facility has communicated to the physician that a resident has had an unwitnessed fall and if the resident is on a blood thinner. If the physician has not been notified, the DON, QI nurse, or weekend supervisor will notify the physician immediately. Beginning 11/7/18, the DON or QI nurse will present the results of the audits and IDT reviews to the monthly QI committee	

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F 580	Continued From page 24 Resident #2 was admitted to the facility on 09/11/18, with a primary diagnosis of uncontrolled diabetes mellitus with hyperglycemia. Resident #2 had insulin orders for 6 units of Regular insulin with meals, 10 units of Detemir (Levemir) at bedtime and a sliding scale of Regular insulin before meals and at bedtime. On 9/11/18 at approximately 4:12 pm, Resident #2's finger-stick blood sugar (FSBS) was 206. Nurse #4 did not administer 2 units of Regular insulin, sliding scale (SS), as ordered by the physician. Nurse #4 did not follow the system place for when medication is not available. Nurse #4 should have obtained insulin from the emergency drug kit (EDK) or contacted the physician to give the physician opportunity to alter treatment. Nurse #4 failed to follow the system in place due to lack of communication during Nurse #4's new employee orientation; upon accessing the EDK, Nurse #4 failed to identify the medication. On 9/11/18 at approximately 5 pm, Resident #2's supper meal coverage dose of Regular insulin 6 units were not given. On 9/11/18 at approximately 8:50 pm, Resident #2's FSBS was 240. 2 Units of SS Regular insulin were not given. On 9/11/18 9 pm, Resident #2's bedtime dose of Levemir 10 units were not given. On the morning of 9/12/18, Resident #2 experienced at FSBS reading of "HI." The resident received two doses of 6 units of Regular insulin; however the resident's FSBS reading	F 580	for four (4) months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The DON or QI nurse will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) Committee for further recommendations and oversight.	

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would not drop below "HI." Resident #2 was sent to the emergency room, where the resident was admitted with Diabetic Ketoacidosis, and placed on an insulin drip to lower his blood sugar.

On 10/17/18, the director of nursing (DON) interviewed Nurse #4 assigned to Resident #2, for date of service 09/11/18, which revealed Nurse #4 did not give the insulin because it was unavailable. The immediate jeopardy (IJ) situation was created when Nurse #4 failed to notify the physician that the insulin for Resident #2 was not available, which did not allow the physician the opportunity to alter treatment orders for Resident #2.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/19/18, the DON and unit manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders.

On 10/22/18 the unit manager contacted the physician regarding undocumented doses of insulin. The physician gave no new orders.

On 10/19/18, the DON and Unit Manager audited to ensure all residents on insulin have the insulin available in the facility. All Residents had Insulin available to match order.

3. What measures will be put into place or systemic changes made to ensure the deficient

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practice will not recur:

On 10/19/18, the DON, QI nurse and staff facilitator (SF) began education with all licensed nurses on the importance of following insulin orders. This education included: 1) the physician must be notified anytime the prescribed insulin is not available to administer as ordered, 2) the contents of the EDK are available for use if the medication ordered for the resident is not available, 3) insulin cannot be missed, the nurse must address immediately.

On 10/21/18, the education was 50% completed with all registered nurses (RNs) and licensed practical nurses (LPNs). No nurse is allowed to work until the education is completed.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning 10/19/18, the DON, QI nurse, SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available and given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly and recorded on the Insulin Audit Sheet. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures.

The daily IDT's role in this plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT

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also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations. On 10/22/18, the administrator notified the QAPI committee of the audit results and the facility's plan of correction, including the QAPI committee's role in the plan of correction.

Beginning 10/19/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained.

Macon Valley Nursing and Rehabilitation Center alleges compliance of removal of IJ as of 10/22/18.

Facility staff were interviewed 10/23/18 and demonstrated they had been trained on the topics of medication administration, and how to call the pharmacy for medications, and to notify the physician if medications weren't available. Immediate jeopardy was removed effective 10/22/18.

2. Review of the Neuro Checks Guide located at each nurse's station revealed neuro checks should be done as follows: every thirty minutes for 4 hours, every hour for 4 hours and every shift for 3 days once initiated.

Resident #20 was admitted to the facility on 09/17/18 with diagnoses included hip fracture repair, high blood pressure, atrial fibrillation, peripheral vascular disease, and chronic obstructive pulmonary disease.

Review of the admission nursing assessment

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dated 09/17/18 revealed Resident #20 was alert to person, place and time.

Review of the On-Call Provider sheet with a Revision Date of 03/05/15 located at each nurse's station revealed the following when calling an on-call provider: Please have the following information ready before calling which included current medications, if reporting a change in condition, have a description of the signs and symptoms associated with the change, a brief synopsis, relevant past history, and incident report.

Review of the physician orders for Resident #20 revealed: On 09/17/18 Coumadin, a blood thinner, 5 milligrams (mg) once a day for atrial fibrillation.

An interview conducted on 10/10/18 at 11:07 AM with Nurse Aide (NA) #1 revealed he had just started his shift and was doing his first set of rounds when he heard Resident #20 screaming around 3:45 PM. He stated he went to her room and she was lying on her right side with her right arm underneath her and her head lying on the floor facing the bed. NA #1 stated Resident #20 was bleeding from skin tears to both sides of her body. He stated the bed was in the high position and there were no fall mats on the floor. NA #1 stated he called a code green for help and Resident #20 was yelling out in pain. He stated NA #2, NA #3, and Nurse #1 came into the room. NA #1 stated Nurse #1 assessed the resident and then the 4 of them moved Resident #20 back to bed using a sheet underneath her. NA #1 stated he did not ask and did not hear Nurse #1 ask Resident #20 if she hit her head on the floor but her head was laying on the floor when he found

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her.

An interview conducted on 10/10/18 at 12:05 PM with NA #3 revealed she helped NA #2 transfer Resident #20 from the chair to the bed on 09/22/18 close to shift change around 2:45 PM and then went back to her hall. She stated she heard the code green around 4:00 PM and went to Resident #20's room. She stated Resident #20 was lying on the floor with her head on the floor facing her bed that was in the high position. NA #3 stated she helped transfer Resident #20 back to bed and then went back to her hall. She further stated Resident #20 was yelling out in pain before, during and after the transfer.

An interview conducted on 10/11/18 at 10:30 AM with NA #2 revealed he had transferred Resident #20 from the chair to the bed just before shift change on 09/22/18 and he was at the nurse's desk and heard the code green called. He stated he went to Resident #20's room and she was lying on the floor on her right side with her right arm twisted underneath her and her head was lying on the floor with the bed in the high position. He stated she was yelling out in pain and was bleeding from some skin tears. NA #2 stated he helped Nurse #1, NA #1 and NA #3 transfer Resident #20 back to bed and then left the room.

An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was called to Resident #20's room by a code green and when she went in the room Resident #20 was lying on her left side with her head on the ground. She stated she didn't remember what position the bed was in. Nurse #1 stated Resident #20 was yelling out in pain while she assessed her but she had good range of motion of all extremities and

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multiple skin tears. Nurse #1 stated Resident #20's Responsible Party (RP) came in during the assessment and felt like the resident had broken her right shoulder/arm and wanted her sent out to the hospital. She stated she told the RP they could have an x-ray done at the facility and it would be quicker than going to the hospital and he was good with doing it that way. Nurse #1 stated she didn't remember calling the on-call provider and thought the on-coming nurse had called them but after reviewing her nurse's notes she stated, "I guess I probably called the physician and got the order for the x-ray of her shoulder." She stated she would not have told the physician Resident #20 was on Coumadin after the unwitnessed fall because she wouldn't have sent Resident #20 out, she would have started neuro checks and monitored her condition. Nurse #1 stated she did not start neuro checks but reported off to the on-coming nurse about the fall. She stated she did have NA #1 obtain vital signs.

Review of the Incident note dated 09/22/18 6:44 PM revealed Resident #20 had multiple skin tears and they were cleaned and treated. The right shoulder was swollen and Responsible Party (RP) felt it was broken and wanted the resident to go to the emergency room. The note revealed Nurse #1 didn't feel her arm/shoulder was broken because she had range of motion and was using it, not in pain while moving. The Physician was contacted. An order for an x-ray was called into the technician and was done at 6:00 PM in the facility.

Review of the physician order's dated 09/22/18 at 4:00 PM an order was written for Resident #20 by Nurse #1 and signed by the Physician for an x-ray of right shoulder to rule out injury from a fall.

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Review of the x-ray right shoulder results dated 09/22/18 revealed there was no evidence of an acute fracture or dislocation.

Further interview with Nurse #1 on 10/11/18 at 1:39 PM revealed she was Resident #20's nurse on 09/23/18 on the 7:00 AM to 7:00 PM shift and the resident was alert, and talking during the morning of 09/23/18. Nurse #1 stated the NA yelled for her and when she got to the room and assessed Resident #20 she had stopped breathing. She stated she checked her code status and she was a DNR so she didn't initiate CPR.

Two attempts were unsuccessful to interview Nurse #2 via phone on 10/11/18 at 2:00 PM and 10/12/18 at 8:40 AM.

An interview conducted on 10/11/18 at 3:57 PM with the facility Physician revealed he did not recall being called about Resident #20's fall on 09/22/18. He stated if he had been called about a resident having an unwitnessed fall was on Coumadin he would have expected her to be sent out to the hospital for evaluation and a Computed tomography, a scan to see inside the body, to rule out a bleed.

An interview conducted on 10/11/18 at 3:04 PM with the Director of Nursing revealed it was her expectation for nurse's to report to the physician that a resident's fall was unwitnessed or witnessed and what medications they were on. She further stated she expected neuro checks to be completed per facility protocol.

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On 10/11/18 at 3:49 PM the Director of Nursing and the Corporate Consultant were notified of Immediate Jeopardy.

On 10/12/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/22/18 at approximately 3:50 pm, Resident #20 was on the floor next to the resident's bed. Resident #20 was on her side, head was on the floor, and demonstrated signs of pain. The nursing assistant called a code to announce the resident's fall in the resident's room.
On 9/22/18 at approximately 3:55 pm, Nurse #1 directed the nursing assistant to take vital signs. Resident #20's vital signs post fall were blood pressure 143/86, pulse 88, respirations 20, tympanic temperature 97.8 F, and oxygen saturation 95%.
On 9/22/18, Nurse #1 and three nursing assistants assisted Resident #20 to the bed.
On 9/22/18 at approximately 4:00 pm, the treatment nurse noted, cleaned, and dressed five (5) skin tears on Resident #20: right upper arm, right forearm, right knee/leg, right lower leg, left foot second toe. After completing the skin tear treatments, the treatment nurse completed five (5) individual flow sheets of non-ulcer skin conditions in the electronic health record under the assessment tab.
On 9/22/18 at approximately 4:00 pm, Nurse #1 noted Resident #20's right shoulder was swollen. The nurse notified the physician and the physician gave an order for an x-ray of the right

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shoulder. Nurse #1 did not notify the physician that the resident had a fall and Nurse #1 did not notify the physician that Resident #20 was taking Coumadin.
On 9/22/18 at approximately 4:30 pm the Nurse #1 initiated neurological checks on Resident #20. On 9/22/18, the Nurse #1 completed five (5) neurological checks on Resident #20: 4:30 pm, 5:00 pm, 5:30 pm, 6:00 pm, and 6:30pm. Nurse #1 documented the neurological checks in Resident #20's electronic health record under nurse progress notes type: neurological observations. Nurse #1 reported off at approximately 7:00 pm to the oncoming shift nurse that x-ray was pending. The oncoming 7:00 pm - 7:00 am Nurse #2 did not document any neurological checks.
On 9/23/18 at approximately 1:48 am, Nurse #2 documented a skilled post-acute note stating neurological: alert and oriented, cardiac: regular rate and rhythm, tachycardic at times, peripheral pulse present, respiratory rate clear, several wounds with dressings intact, clean, and dry.
On 9/23/18 at approximately 12:45 pm, Nurse #1 completed a discharge summary in Resident #20's electronic health record. The summary included: the assigned nursing assistant was unable to attain vital signs, the Nurse #1 was unable to attain vital signs. The Nurse #1 contacted 911. Resident #20's husband was at bedside. Resident #20 was a Do Not Resuscitate (DNR). Resident #20 was pronounced dead at approximately 12:45 pm.
On 10/11/18, the DON re-educated Nurse #1 regarding resident incident/accidents, post-fall assessments, neurological checks for all unobserved falls, documentation, shift change report, and reporting all relevant information to the physician, nurse practitioner, and DON.

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On 10/11/18, the DON re-educated Nurse #2 regarding resident incident/accidents, post-fall assessments, neurological checks for all unobserved falls, documentation, shift change report, and reporting all relevant information to the physician, nurse practitioner, and DON.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/11/18, the quality improvement (QI) nurse audited 100% of resident current medication administration records (MARs) to identify all residents with current orders to receive Coumadin. The audit identified one (1) resident with Coumadin listed on the MAR.
On 10/11/18, the director of nursing (DON) performed an audit on 100% of residents receiving Coumadin. The audit was to identify any Coumadin resident having a fall within the past 60 days. The audit identified zero/no resident currently taking Coumadin who had a fall within the past 60 days.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all RNs, LPNs, MAs, NAs, and contracted therapy personnel. The re-education covered: In the event of any/all falls, especially for those residents receiving medication that has blood thinning properties, the physician must be called right away. Nurses, including Nurse #1 and Nurse #2, are being instructed to use the PCC E-Interact form to ensure the nurse provides the physician with all

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relevant information for all falls. Nurses will document relevant information on the 24 hour report sheets and report relevant information to the on-coming shift nurse regarding all falls. Nurses must follow the facility's policy on PT/INRs when resident is on Coumadin. Nurses are being instructed to start neuro-checks and follow the posted neuro-check guidelines which details the frequency of performing the neuro-check; only licensed registered nurses and licensed practical nurses will perform the neuro-checks, NAs may take the vital signs. Repeat PT/INR after three days or as ordered by the physician/nurse practitioner. If the resident has to be sent out for evaluation and treatment due to an injury post-fall and the resident returns to the facility the neurological checks must be re-started at the appropriate time. The DON must be notified within two hours of all falls with injuries to ensure proper interventions are in place. The re-education was completed on 10/11/18 with all staff working; no RN, LPN, MA, NA, or contracted therapy personnel will be allowed to work, including Nurse #1 and Nurse #2, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, MAs, NAs, and contracted therapy personnel.

On 10/11/18, the QI nurse initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs, including Nurse #1 and Nurse #2, to enter all neurological checks into the electronic medical record (PCC) under neurological observation. By having neurological observations documented in the PCC system, the documents are available for review by the physician, nurse practitioner, and clinical teams. The in-service was completed on 10/11/18 with all staff working; no RN or LPN will be allowed to

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work until the re-education is completed, including Nurse #1 and Nurse #2. The re-education is added to the new staff orientation for all RNs and LPNs.
On 10/11/18, the DON initiated in the morning inter-disciplinary team (IDT) meeting a review of all falls, to include residents on medication with blood-thinning properties. The review included verifying that an assessment was completed immediately post-fall, that the physician/nurse practitioner was notified of all falls with all relevant information provided. The resident representative was notified, if the resident is on medication with blood-thinning properties, if the resident required outside treatment, and if the DON was notified of the fall.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning 10/11/18, the DON and/or QI nurse will review the 24 hour report sheets for all falls.

Beginning 10/11/18, the DON, QI nurse, and/or staff facilitator will review the 24 hour PCC progress notes. Beginning 10/11/18, the 24 hour report sheet review findings will be reconciled with the 24 hour PCC progress note review findings to ensure all falls have documented assessments and reports to physician/nurse practitioner which include current medications with blood-thinning properties including Coumadin. These reviews and reconciliations will be completed five times each week for a period of six months.

On 10/11/18, the DON and corporate clinical

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F 580	Continued From page 37 director notified the daily quality assurance and performance improvement (QAPI) team. The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team also making recommendations for revisions as needed. The daily QAPI review findings will be brought to the next quarterly QAPI meeting for additional review and recommendations. Beginning 10/11/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley alleges credible allegation of IJ removal as of 10/11/18. On 10/12/18 facility staff were interviewed and demonstrated they had been trained on the topics of using the PCC E-Interact forms to ensure nurses provided the physician with all relevant information after falls, when and how to perform neuro checks, DON notification, reporting of falls to on-coming nurse, and documenting on the 24 hour report sheets. Immediate jeopardy was removed effective 10/11/18.	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 homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		12/5/18

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F 584	Continued From page 38 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, staff and family interviews, the facility failed to keep the floor clean in 1 of 17 sampled resident rooms. This affected Resident #1. The findings included: Resident #1 was admitted to the facility on	F 584	F584 How corrective action will be accomplished for those residents found to have been affected by the deficient practice	

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F 584	Continued From page 39 07/09/18. The admission Minimum Data Set dated 07/16/18 revealed he had severe cognitive impairment. On 10/09/18 at 6:53 AM, the floor between Resident #1's bed and the door was observed with sticky dark residue and smudges and two spots of dried red food residue in front of the bedside table. On 10/09/18 at 12:12 PM Housekeeper #1 swept and mopped the floor. She stated that this room had some messes at times due to residents spitting and so she always made a second round in the afternoon to check for any additional cleaning needs. If she found messes she stated she usually cleaned them up. On 10/09/18 at 1:08 PM, the floor was still sticky with residue, the dried red food spill was still present and there was a napkin on the floor. This observation was prior to the lunch meal being served. The spills and soiled floor remained next to Resident #1's bed on the floor when observed on 10/09/18 at 3:02 PM. Observations on 10/10/18 at 8:30 AM revealed the floor was still sticky, smudged and with red dried food debris by Resident #1's bed. Phone interview with family on 10/10/18 at 10:30 AM revealed the family was concerned that the floor was always dirty in Resident #1's room. The floor remained soiled when observed on 10/10/18 at 11:58 AM. On 10/10/18 at 12:18 PM Housekeeper #2 was observed sweeping and mopping Resident #1's room. The housekeeper did not move the wheelchairs in the room or the overbed tables.	F 584	On 10/10/18, the housekeeping supervisor and housekeeper deep cleaned Resident #1's room, including the floor. After the floor was cleaned there was no sticky residue, dried food spill, or debris on the floor. Starting 10/10/18, the housekeeping supervisor ensured Resident #1's room floor was cleaned daily to remove sticky residue, dried food spill, and debris. How the facility will identify other residents having the potential to be affected by the same deficient practice On 11/2/18, the housekeeping supervisor in-serviced the housekeeping staff on housekeeping policies and procedures to ensure a safe/clean/comfortable/homelike environment. After 11/2/18, no housekeeping staff were allowed to work before completing the in-service. On 11/12/18, the housekeeping supervisor completed the in-service with 100% of the housekeeping staff. The in-service will be included with orientation for all new housekeeping staff. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/12/18, the housekeeping supervisor completed a 100% audit of all resident rooms inspecting for spills and	

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F 584	Continued From page 40 She was observed to mop along Resident #1's bed but because no furniture was moved, the red dried food spill remained. A lunch ticket form another day was on the floor under the bed. Housekeeper #2 stated during interview on 10/10/18 at 1:58 PM she tried to move as much furniture as she could during sweeping and mopping but this room was very crowded. Housekeeper #2 observed the spill and paper on the floor and stated she would have to scrape the debris up next to Resident #1's bed. The Housekeeping supervisor stated during interview on 10/10/18 at 2:10 PM that she expected furniture to be moved during mopping except that under the beds could be accessed with the mop.	F 584	dried food on floors. The audit revealed spills and dried food debris on multiple resident room floors. The housekeeping supervisor and housekeepers cleaned the resident room floors, including Resident #1's floor. On 11/12/18, the director or nursing (DON), and quality improvement nurse (QI) began an in-service with all nursing staff (registered nurses, licensed practical nurses, medication aides, nursing assistants, geriatric care assistants) on immediately cleaning up spills, including the floors. The in-service also instructed the nursing staff to remove trash and place a new liner in the trash can upon exiting the resident's room. This in-service was completed 11/25/18. After 11/25/18, no nursing staff will be allowed to work until the in-service is completed. This in-service will be part of the orientation for new nursing staff. On 11/12/18, the housekeeping supervisor in-serviced the housekeeping staff on: 1) increasing the number of rounds made to ensure the floors in the resident rooms are free of spills and dried food debris, including moving furniture and mobility devices and 2) proper cleaning of the resident rooms. Starting 11/12/18, the in-service became part of the orientation for any new housekeeping employee. How the facility plans to monitor its performance to make sure that solutions	

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F 584	Continued From page 41	F 584	are sustained The administrator, DON, weekend nurse supervisor, social worker, maintenance director, accounts receivable, payroll, social worker, activity director, weekend manager on duty, and/or licensed nurse will audit 10 resident rooms weekly x 12 weeks, including bathrooms, to ensure resident room floors are free of dried food debris. This audit will be documented on the Department Head Round audit tool. The housekeeping supervisor will review the results of the Department Head Round audit tool monthly. The housekeeping supervisor will report to the monthly quality improvement (QI) committee to identify trends, the need for an increase or decrease of frequency of auditing for continued compliance. The administrator and/or housekeeping supervisor will take the recommendations of the monthly QI committee to the quarterly quality assurance and performance improvement (QAPI) committee for additional recommendations and oversight.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		12/5/18

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F 600	Continued From page 42 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a resident's right to be free from physical and verbal abuse 1 of 3 residents reviewed for abuse (Resident #3). Immediate jeopardy began on 10/01/18 when Nurse Aide (NA) #1 observed NA #8 forcibly trying to make Resident #3 sit down on the toilet and yelling at her for being soiled. Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. Based on record review, resident, staff, and Nurse Practitioner interviews the facility failed to administer insulin per physician order's or contact physician which caused the resident to be sent out to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed with insulin dependent diabetes (Resident #2). Immediate Jeopardy began on 09/11/18 when Nurse #4 did not administer insulin per physician's order or contact physician which resulted in Resident #2 developing DKA.	F 600	F 600 How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/11/18, the treatment nurse completed a head-to-toe physical and emotional assessment of Resident #3. The assessment revealed no new changes in Resident #3's skin condition or behavior. On 10/11/18, the DON ensured Nursing Assistant #1 was not working at the facility and Nursing Assistant #8 was re-educated on abuse and immediate in-person reporting. On 10/11/18 at approximately 5pm the DON initiated resident abuse re-education for all facility staff, including contracted staff. On 10/15/18 Nursing Assistant # 1 was re-educated on abuse, both verbal and physical abuse. On 09/12/18, Nurse #3 notified the nurse practitioner that Resident #2's blood sugar was reading "HI". The nurse practitioner gave a verbal order for Resident # #2 to be sent to emergency room. Resident #2 was sent to the emergency room, where	

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F 600	Continued From page 43 Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: 1. Resident #3 was admitted to the facility on 03/30/18 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 07/06/18 revealed Resident #3 was severely cognitively impaired. The MDS further revealed Resident #3 had delusions, physical and verbal behaviors toward others, rejection of care and wandering 1 to 3 days during the assessment period. Review of the nurse's notes from 09/30/18 through 10/12/18 revealed no documentation of Nurse Aide (NA) #1 having concerns that NA #8 had been physically or verbally abusive to Resident #3 on the morning of 10/01/18. Review of the facility incident reports from 09/30/18 through 10/12/18 revealed there was no incident report for alleged physical/verbal abuse of Resident #3 by NA #8 on 10/01/18. An interview conducted on 10/11/18 at 10:36 AM with NA #1 revealed he worked the 7:00 AM to 3:00 PM shift on the Sparks Unit on 10/01/18. NA #1 stated when he went onto the unit that	F 600	the resident was admitted with diabetic ketoacidosis, and placed on an insulin drip to lower the blood sugar level. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/11/18, the treatment nurse performed a head-to-toe skin audit on 100% of dementia unit residents to identify any residents with signs/symptoms of abuse. The audit identified no findings. On 10/11/18, the DON instructed the Social Services Director (SSD) to perform Resident Abuse/Neglect Questionnaires with the alert and oriented residents. The questionnaires revealed no further allegations of abuse. On 10/19/18, the DON and unit manager reviewed all facility residents receiving insulin to ensure insulin was available and had been administered as ordered. This review compared each resident's current insulin orders with the medication administration record (MAR) and the insulin available in the medication carts. On 10/22/18, the unit manager notified the medical director of the audit results including insulin omission for affected residents. No new orders were received. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur	

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F 600	Continued From page 44 morning the 11:00 PM to 7:00 AM NA #8 was not out on the floor and he assumed she was with a resident. He stated he was at the nurse's station and he heard Resident #3 start screaming and immediately went to her room because it wasn't Resident #3's normal behavior to scream or yell out. NA #1 stated when he went into Resident #3's room she was in the bathroom with NA #8, who was yelling at her and was forcibly trying to make her sit down on the commode. He stated NA #8 was yelling at Resident #3 because she had been incontinent and had feces running down her legs and wouldn't sit down on the commode. NA #1 stated he told NA #8 it was time for her to leave the room because he thought she was being too rough with the resident and he would finish taking care of Resident #3 but she refused and told him she wasn't finished with her yet. He stated he left the room to get some gloves to go back in to help NA #8 and Medication Aide (Med Aide) #9 and Med Aide #10 were at the medication cart counting meds and he told them what was happening. NA #1 stated when he went back in Resident #3's bathroom NA #8 told him to leave. NA #1 stated he went back out to the nurse's station and wrote a statement of what had happened and had Med Aide #9 write a statement of what she heard and took them to the sub-acute hall to Nurse #1 and reported the incident because she was the Nurse that covered the Sparks Unit. An interview conducted on 10/11/18 at 11:01 AM with Med Aide #9 revealed she worked as a Medication Aide on the Sparks Unit on 10/01/18 7:00 AM to 7:00 PM shift and was counting medications with the off-going Med Aide on the Sparks Unit around 7:00 AM. Med Aide #9 stated she heard Resident #3 screaming like she was in	F 600	On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all staff including agency staff and contracted therapy staff. The re-education covered: Abuse/Neglect and reporting any abuse allegation immediately to the Administrator or Director of Nursing 24 hours a day. All staff, all departments, all contracted employees, including Nursing Assistant #1 and Nurse #1, are being instructed to keep resident safe at all times. If you suspect a resident is in harm's way do not leave the resident and call for help. All staff are responsible for keeping our residents safe at all times. On 10/19/18, the administrator, DON, QI nurse, and staff facilitator initiated small group meetings with 100% of staff, including contracted and agency staff, to discuss the facility's zero tolerance for abuse and not abusing residents. The no abuse discussions were presented with the burnout in-service to help staff recognize preventative measures that will ensure residents are not abused but treated with dignity and respect. No staff, including contracted and agency staff will be allowed to work until participating in the small group discussions and completing the burnout education. The small group meetings and burnout in-service were completed by 10/31/18. The discussion and in-service were added to new employee orientation, including contracted and agency staff. On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing 100% of residents on	

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F 600	Continued From page 45 pain, which wasn't normal behavior for her and then NA #1 came out of her room and told her NA #8 had Resident #3 in the bathroom and was being rough with her, trying to make her sit on the commode and yelling at her for having feces running down her legs because she had to clean her up. Med Aide #10 stated NA #1 told her he tried to get NA #8 to leave the room but she refused and he came out to get some gloves to go back in to help her. She stated she observed NA #1 go back into Resident #3's room and then come back out and he told her NA #8 told him to get out. Med Aide #9 stated she wrote a statement of what she heard, observed, and was told by NA #1 and he took the statements to Nurse #1 on the sub-acute hall to report the incident because she also was the nurse covering the Sparks Unit. An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was on the sub-acute hall receiving report from the off-going 7:00 PM to 7:00 AM shift Nurse #5, when NA #1 came to her and told her there had been an incident of abuse with NA #8 and Resident #3 on the Sparks Unit and gave her 2 written statements. Two attempts were unsuccessful to interview NA #8 via phone on 10/11/18 at 2:00 PM and 10/11/18 at 4:00 PM. An interview conducted on 10/11/18 at 2:18 PM with Nurse #5 revealed she was giving report to Nurse #1 on 10/01/18 when NA #1 came up and pulled Nurse #1 to the side and told her NA #8 and Resident #3 had an incident and he thought NA #8 had been verbally and physically abusive with Resident #3.	F 600	insulin once daily 5 times weekly x 12 weeks to ensure insulin is available for administration as ordered. This audit will be documented on the insulin audit tool. On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing audit 100% of residents on insulin. The auditing will be completed once daily 5 times weekly x 12 weeks to ensure insulin was administered as ordered. This audit will be documented on the insulin audit tool. On 10/20/18, the DON, QI nurse, SF, and/or administrator began reviewing all referrals to ensure if a potential resident would be on insulin and the medication is available prior to resident admission. This audit will be documented on the insulin referral audit tool. This audit will be completed on each referral for 12 weeks. How the facility plans to monitor its performance to make sure solutions are sustained Starting on 10/19/18, the Social Worker (SW) began weekly rounds asking all alert and oriented residents if staff are being good to the residents. The weekly rounds will be completed for 6 months. Starting on 10/19/18, the administrative nursing staff (DON, quality improvement nurse, treatment nurse, unit manager, weekend supervisor, minimum data set nurse) will monitor direct care of 10 % of residents daily from varied shifts for 4 weeks, then weekly for 4 weeks, then monthly for 6 months to ensure no abuse	

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F 600	Continued From page 46 On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone. On 10/22/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 10/1/18 at approximately 7:15am, Resident #3 was yelling and Nursing Assistant (NA) #1 went to check on Resident #3 and Nursing Assistant #8 abused the Resident by taking Resident #3's hand and pushed her onto the toilet. Nursing Assistant # 8 yelled at Resident # 3. NA #1 asked NA #8 to leave the bathroom and NA #8 refused. " On 10/1/18 at approximately 7:30am, Nursing Assistant #1 returned Resident #3 to the resident's room. " On 10/11/18 at approximately 4:10 pm the director of nursing (DON) determined there was an allegation of abuse and abuse potentially occurred when Nursing Assistant #8 was providing incontinent care to Resident #3 in the dementia unit bathroom on 10/01/18. The abuse occurred when Nursing Assistant #8 took Resident #3's hand and pushed Resident #3 onto the toilet. " On 10/11/18 at approximately 4:20pm, the treatment nurse completed a head-to-toe physical and emotional assessment of Resident #3. The	F 600	is occurring. Starting 10/19/18, the results will be taken to the quality assurance and performance improvement (QAPI) meeting monthly for discussion and further recommendations. Beginning 10/19/18, the DON, QI nurse, SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available and given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly and recorded on the Insulin Audit Sheet for three months then weekly for three months. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures. Beginning 10/20/18 the DON will present the Insulin Audit Sheet results to the interdisciplinary team (IDT) weekly for review for six months. This review will include ensuring insulin was administered as ordered and insulin is available for administration. Presentation of the Insulin Audit Sheet to the IDT will serve as a second verification. Beginning 10/20/18, the DON will present the insulin referral audit tool results to the IDT weekly for review for six months. This review will ensure potential admissions with a need for insulin have the medication available upon admission. Presentation of the insulin referral audit	

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F 600	Continued From page 47 assessment revealed no new changes in Resident #3's skin condition or behavior. " On 10/11/18 at approximately 4:30pm, the DON ensured Resident #3 was safe from abuse; the DON ensured Nursing Assistant #8 was not working at the facility and Nursing Assistant #1 was re-educated on abuse and immediate in-person reporting. On 10/11/18 at approximately 5pm the DON initiated resident abuse re-education for all facility staff, including contracted staff. " On 10/15/18 at 3:00pm Nursing Assistant # 8 was re-educated on abuse, both verbal and physical abuse. " On 10/19/18, the administrator held an emergency interdisciplinary team (IDT) meeting to discuss a root cause analysis to know why the Nursing Assistant #8 abused Resident #3 and how the facility can fix the problem. The IDT reviewed Nursing Assistant #8's work hours for the previous two weeks and noted the nursing assistant had worked overtime. The IDT also reviewed Resident #3's progress notes and care plan and noted the resident has on-going difficult behaviors. The IDT determined the root cause was Nursing Assistant #8 was tired, frustrated, and didn't receive assistance needed to meet the resident's needs. In response to the root cause, the IDT determined the staff required re-training on resident abuse and new training on recognizing burnout and working as a team. An addition, the administrator added additional staff to the staff assignments. The DON, the Administrator, the Facility Consultant, and the Vice President of Operations interviewed Nursing Assistant #1. The Nursing Assistant was	F 600	tool to the IDT will serve as a second verification. The daily IDT's role in this plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations.	

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re-educated on never leaving a resident who they feel is being abused and to yell for assistance from other staff. Nursing Assistant # 1 was also re-educated on calling the Administrator or Director of Nursing to never leave notes for any abuse/neglect allegation.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/11/18, the treatment nurse performed a head-to-toe skin audit on 100% of dementia unit residents to identify any residents with signs/symptoms of abuse. The audit identified no findings.
On 10/11/18, the DON instructed the Social Services Director (SSD) to perform Resident Abuse/Neglect Questionnaires on the residents. The questionnaires revealed no further allegations of abuse.
Starting on 10/19/18, the Social Worker (SW) will do weekly rounds asking all interview able residents if staff are being good to the residents. The weekly rounds will be completed for 6 months.
On 10/19/18, the administrative nursing staff will monitor direct care of 10 % of residents daily from varied shifts for 4 weeks, then weekly for 4 weeks, then monthly for 6 months to ensure no abuse is occurring. Starting 10/19/18, the results will be taken to the quality assurance and performance improvement (QAPI) meeting monthly for discussion and further recommendations.

3. What measures will be put into place or systemic changes made to ensure the deficient

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practice will not recur:

" On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all staff including contracted staff. The re-education covered: Abuse/Neglect and reporting any abuse allegation immediately to the Administrator or Director of Nursing 24 hours a day. All staff, all departments, all contracted employees, including Nursing Assistant #1 and Nurse #1, are being instructed to keep resident safe at all times. If you suspect a resident is in harm's way do not leave the resident and call for help. All staff are responsible for keeping our residents safe at all times.

" On 10/19/18, the administrator, DON, QI nurse, and staff facilitator initiated small group meetings with 100% of staff, including contracted and agency staff, to discuss the facility's zero tolerance for abuse and not abusing residents. The no abuse discussions were presented with the burnout in-service to help staff recognize preventative measures that will ensure residents are not abused but treated with dignity and respect. No staff, including contracted and agency staff will be allowed to work until participating in the small group discussions and completing the burnout education. The small group meetings and burnout in-service will be completed by 10/31/18. The discussion and in-service will be added to new employee orientation, including contracted and agency staff.

" Starting 10/19/18, the Social Worker (SW) will do weekly rounds asking interview able residents if staff are not abusing resident but treating residents with dignity and respect. The weekly SW rounds will be completed for 6 months and the results taken to the monthly QAPI meetings for review and further

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recommendations.
" Starting on 10/19/18, the administrative nursing staff will monitor direct care of 10 % of residents daily from varied shifts x 4 weeks, then weekly x 4 weeks, then monthly for 6 months to ensure no abuse is occurring. Starting on 10/19/18, the audit results will be taken to the QAPI meeting monthly for discussion and further recommendations.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

" On 10/11/18, the DON and corporate clinical director notified the daily quality assurance and performance improvement (QAPI) team. The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team also making recommendations for revisions as needed. The daily QAPI review findings will be brought to the next quarterly QAPI meeting for additional review and recommendations.
" On 10/19/18, The Social Worker will do weekly rounds asking interview able residents if staff are being good to the residents for 6 months.
" On 10/19/18, The Administrative nursing staff will monitor direct care of 10% of resident's daily from varied shifts for 4 weeks, then weekly for 4 weeks, then monthly for 6 months starting 10/19/2018 to ensure no abuse is occurring.

" On 10/19/18, the results will be taken to the QAPI meeting monthly for discussion. Beginning 10/19/18, the administrator will be

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responsible for implementing and monitoring corrective measures to ensure solutions are sustained.
Macon Valley alleges compliance of removal of IJ as of 10/22/18.

On 10/23/18 facility staff were interviewed and demonstrated they had been trained on the topics residents having the right to be free from abuse and abuse would not be tolerated at the facility. Immediate jeopardy was removed effective 10/22/18.
2. Resident #2 was admitted to the facility on 9/11/18 with diagnoses which included: diabetes, heart disease, chronic kidney disease, and peripheral vascular disease.

Review of the Medication Administration Record (MAR) for September 2018 for Resident #2 revealed on 09/11/18 Resident #2 was given 6 units of scheduled regular insulin at 12:00 PM and an additional 2 units of sliding scale insulin (SSI) for coverage of capillary blood glucose (CBG) reading of 236.

Review of the September 2018 MAR further revealed Resident #2 did not receive his physician ordered insulin's of 6 units on 09/11/18 at 5:00 PM and 10 units at 9:00 PM and his sliding scale insulin coverage at 4:30 PM for a CBG of 206 that required 2 units of coverage and 8:30 PM for a CBG of 240 that required 2 units of coverage.

A record review of the September 2018 MAR further revealed Resident #2 received the physician ordered 6 units of regular insulin on 09/12/18 at 8:00 AM. Resident #2 also received 6 units of SSI regular insulin on 09/12/18 at 7:30

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AM to cover a CBG of "HI".
Review of the Blood Glucose Monitoring Sheet for 09/11/18 for Resident #2 revealed the following readings:

09/11/18 1:00 PM CBG 236
09/11/18 4:12 PM CBG 206
09/11/18 8:50 PM CBG 240

Per physician order and based on CBG reading of 206, Resident #2 should have received 2 units regular insulin on 09/11/18 at 4:30 PM.

Per physician order and based on CBG reading of 240, Resident #2 should have received 2 units regular insulin on 09/11/18 at 8:30 PM.

An interview with Nurse #3 on 10/09/18 at 1:00 PM revealed she gave Resident #2 12 units of regular insulin on 09/12/18 at 7:30 AM. This included the 6 units of regular scheduled insulin and 6 units of regular insulin for SSI coverage of CBG reading "HI". Nurse #3 further revealed the recheck of Resident #2's CBG at 9:30 AM still read "HI". Nurse #3 notified the NP, who was at the facility and she examined the resident and ordered him transferred to the hospital for possible DKA.

An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his physician ordered insulin's on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. She further stated she did not give Resident #2 his Detemir insulin scheduled for 09/11/18 at 9:00 PM. She stated she did not look for the insulin and just did not give it.

An interview with Nurse #3 on 10/10/18 at 9:30

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AM revealed she obtained the regular insulin administered to Resident #2 on 09/11/18 and 09/12/18 from house stock in the emergency box.

Review of the nurse notes dated 09/12/18 at 2:05 PM revealed the CBG taken at 7:30 AM read "HI". The nurse gave Resident #2 12 units of regular insulin per physician admission orders. The CBG was rechecked at 9:30 AM which read "HI". The note further revealed Resident #2 was vomiting and not feeling well and was seen by the Nurse Practitioner (NP) who wrote an order for transfer Resident #2 to the emergency department for evaluation of possible DKA.

Review of the Nurse Practitioner (NP) progress note dated 9/12/18 indicated Resident #2 was seen on 09/12/18 after a CBG reading was 'HI'. The progress note indicated Resident #2 had also developed nausea and vomiting and he was clammy and anxious. An order was given by the NP to transfer the resident to the emergency department for possible DKA.

An interview with the NP on 10/10/18 at 10:00 AM revealed she was unaware Resident #2 had not received his insulin's the evening before he was sent to the hospital. Further interview with the NP revealed her expectation was for the facility nurse to contact the on-call physician if the insulin was not available.

An interview with Nurse #4 on 10/10/18 at 10:45 AM revealed she did not remember if she had reported to the 3rd shift nurse that Resident #2 had not received his insulin. She stated she did not contact the on-call physician to notify them of the unavailability of insulin. Nurse #4 further stated she did not call the pharmacy to obtain the

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insulin or look for the insulin in the emergency box which contains emergency medications.

During an interview with Director of Nursing on 10/09/18 at 4:05 PM she stated she expected the facility staff to contact the physician for all missing medications. She further stated she expected staff to check for the ordered medications in the emergency box and to contact pharmacy for missing medications.

Review of the hospital records revealed Resident #2 was admitted to the hospital intensive care unit for DKA on 09/12/18. Blood sugar on admission to the hospital was 485. Resident #2 required an insulin drip which he was weaned from the morning of 09/13/18. He was discharged on 09/14/18.

On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone.

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On September 11, 2018 at approximately 11:30am, Resident #2 was admitted to Macon Valley Nursing and Rehabilitation center following a hospitalization for diagnosis including uncontrolled diabetes type 1.

On September 11, 2018 at 11:30 am, Resident #2 had a blood glucose reading of 236; blood glucose procedure was performed by Nurse #3.

On September 11, 2018 at 11:30 am, Resident #2 was given 2 units of regular insulin

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subcutaneously by Nurse #3, according to physician order, for blood glucose of 236.

On September 11, 2018 at 12 noon, Resident #2 was given regular insulin 6 units subcutaneously, according to physician order, for scheduled insulin by Nurse #3.

On September 11, 2018 at 4:12 pm, Resident #2 had a blood glucose reading of 206; blood glucose procedure was performed by Nurse #4.

On September 11, 2018 no documentation that Resident #2 received 2 units of regular insulin for blood glucose of 206, as ordered by physician.

On September 11, 2018 5:00 pm, Resident #2 has no documentation of administration of scheduled dose of 6 units of regular insulin, as ordered by physician.

On September 11, 2018 at 8:50 pm, Resident #2 had a blood glucose reading of 240; procedure was performed by Nurse #4.

On September 11, 2018 at 8:50 pm, Resident #2 has no documentation of administration of 2 units regular insulin for a blood glucose reading of 240, as ordered by physician.

On September 11, 2018 at 9:00 pm, Resident #2 has no documentation of administration of Levemir 10 units, as ordered by physician.

On September 12, 2018 at 7:30 am, Resident #2 had a blood glucose result of HI; procedure was performed by Nurse #3.

On September 12, 2018 at 7:30 am, 6 units

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Regular Insulin subcutaneous was administered by Nurse #3, as ordered by the physician, to Resident #2.

On September 12, 2018 at 8:00, am Resident #2 was administered Regular Insulin 6 units subcutaneous by Nurse #3, for schedule insulin dose as ordered by physician.

On September 12, 2018 at 9:30 am, Nurse #3 rechecked Resident #2's blood glucose with a result of HI.

On September 12, 2018 approximately 9:30, am the nurse practitioner was notified of blood glucose reading remaining HI, the action taken by Nurse #3 of administrating 6 units of regular insulin for the initial HI reading, and Nurse #3 administering the 6 units of regular insulin as scheduled by Nurse #3 for Resident #2.

On September 12, 2018, the nurse practitioner gave a verbal order to Nurse #3 for Resident # #2 to be sent to emergency room.

On September 12, 2018, Resident #2 was sent to the emergency room, where the resident was admitted with diabetic ketoacidosis, and placed on an insulin drip to lower the blood sugar level.

On October 19, 2018 the DON initiated abuse/neglect re-education to correct the staff involved in the deficient practice. The neglect re-education covered that neglect includes not providing medications as ordered. The neglect re-education will be covered with 100% staff, including Nurse #4 and agency staff. No nurse is allowed to work until the education is completed.

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On October 19, 2018 all licensed nurses, including agency staff, were in-serviced on administering medication per physician orders, including obtaining medications when not available on the medication cart/in the facility.

On October 22, 2018, the facility determined the root cause of the deficient practice that led to neglect of Resident #2 was the nurse's failure to follow established policy in obtaining medications when the medication is not available on the medication cart.

On 10/19/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On October 19, 2018, the director of nursing (DON) and Unit Manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders. On 10/22/18 the unit manager contacted the physician regarding undocumented doses of insulin. The physician gave no new orders.

On October 19, 2018, the DON and Unit Manager audited to ensure all residents on insulin have the insulin available in the facility. All Residents had Insulin available to match order.

On October 11, 2018, the DON instructed the social worker (SW) to perform resident

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abuse/neglect questionnaires with the residents. The questionnaires results revealed no further allegations of abuse.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On October 20, 2018, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing 100% of residents on insulin once daily 5 times weekly x 12 weeks to ensure insulin is available for administration as ordered. This audit will be documented on the insulin audit tool.

On October 20, 2018, the DON, quality improvement (QI) nurse, staff facilitator (SF), administrator, and/or licensed nurse began auditing audit 100% of residents on insulin. The auditing will be completed once daily 5 times weekly x 12 weeks to ensure insulin was administered as ordered. This audit will be documented on the insulin audit tool.

On October 20, 2018, the DON, QI nurse, SF, and/or administrator began reviewing all referrals to ensure, if a new admission resident is on insulin, the insulin medication is available prior to the resident's new admission. This audit will be documented on the Insulin Referral Audit tool. This audit will be completed for 12 week for each referral before admission.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning October 19, 2018, the DON, QI nurse,

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SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available and given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly and recorded on the Insulin Audit Sheet. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures.

Beginning October 20, 2018 the DON will present the Insulin Audit Sheet results to the interdisciplinary team (IDT) weekly for review. This review will include ensuring insulin was administered as ordered and insulin is available for administration. Presentation of the Insulin Audit Sheet to the IDT will serve as a second verification.

Beginning October 20, 2018, the DON will present the insulin referral audit tool results to the IDT weekly for review. This review will ensure potential admissions with a need for insulin have the medication available upon admission. Presentation of the insulin referral audit tool to the IDT will serve as a second verification.

The daily IDT's role in this plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations. On 10/22/18, the administrator notified the QAPI committee of the significant medication error lJ

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F 600	Continued From page 60 and the facility's plan of correction, including the QAPI committee's role in the plan of correction. Beginning October 19, 2018, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley Nursing and Rehabilitation Center alleges compliance of removal of IJ as of October 22, 2018. On 10/23/18 facility staff were interviewed and demonstrated they had been trained on the topics of medication administration, and how to call the pharmacy for medications. Immediate jeopardy was removed effective 10/22/18.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy and procedures in the areas of prevention, identification, protecting, reporting, and	F 607	F 607 □ Implement Abuse/Neglect Policy How corrective action will be	12/5/18

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F 607	Continued From page 61 investigating for 1 of 3 residents reviewed for abuse (Resident #3). Immediate jeopardy began on 10/01/18 when Nurse Aide (NA) #1 observed NA #8 forcibly trying to make Resident #3 sit down on the toilet and yelling at her for being soiled. NA #1 reported the incident to Nurse #1, who did not assess Resident #3 or report the abuse to the Director of Nursing or the Administrator. Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Review of the facility Abuse, Neglect, or Misappropriation of Resident Property Policy dated 01/2009 with a revision date of 03/10/17 read in part: The facility believes that residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation, or misappropriation of property. The facility will do whatever is in its control to prevent mistreatment, neglect, exploitation, and abuse of our residents or misappropriation of their property. Any employee who witnesses or suspects that abuse, neglect, exploitation, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, exploitation, abuse, or misappropriation of property will result in	F 607	accomplished for those residents found to have been affected by the deficient practice: On 10/1/18 at approximately 7:00 am, Resident #3 was in the dementia unit bathroom. Resident #3 was sitting, clothed, in a wheelchair. Nursing Assistant #8 was assisting Resident #1 with ADL care. On 10/1/18 at approximately 7am, Nursing Assistant #1 observed Resident #3 in the dementia unit bathroom loudly screaming. Nursing Assistant #1 asked Nursing Assistant #8 what she needed. Nursing Assistant #8 replied wipes now. Nursing Assistant #1 then went to the linen room and obtained wipes. On 10/1/18 at approximately 7:15am Nursing Assistant #1 states that he saw Nursing Assistant #8 take residents hand and push her onto the toilet and yelled at her. On 10/1/18, at approximately 7:35 am Nursing Assistant #1 reported the observations of Nursing Assistant #8□s interactions with Resident #3 in the bathroom to Nurse #1. Nurse #1 collected statements from Medication Aide #9 and Nursing Assistant #1. Nurse #1 placed the statements under the administrator□s door at approximately 7 pm before leaving work. The administrator never received the statements from Medication Aide #9 or Nursing Assistant #1. On 10/1/18 Nurse #1 did not assess resident after allegation of abuse was made.	

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F 607	Continued From page 62 disciplinary action and possible termination of employment. The Administrator is responsible to ensure that complaints of abuse, neglect, exploitation, or misappropriation of property and injuries of unknown origin are investigated. Measures will be implemented to prevent further potential abuse, while the investigation is in progress. The Administrator is responsible to review the results of the investigation and report the alleged incident to the appropriate agencies in accordance with state and federal regulations. Resident #3 was admitted to the facility on 03/30/18 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 07/06/18 revealed Resident #3 was severely cognitively imapaired. The MDS further revealed Resident #3 had delusions, physical and verbal behaviors toward others, rejection of care and wandering 1 to 3 days during the assessment period. Review of the nurse's notes from 09/30/18 through 10/12/18 revealed no documentation of Nurse Aide (NA) #1 or NA #9 having concerns that NA #8 had been physically or verbally abusive to Resident #3 on the morning of 10/01/18. Review of the facility incident reports from 09/30/18 through 10/12/18 revealed there was no incident report for alleged physical/verbal abuse of Resident #3 by NA #8 on 10/01/18. An interview conducted on 10/11/18 at 10:36 AM with NA #1 revealed he worked the 7:00 AM to 3:00 PM shift on the Sparks Unit on 10/01/18. NA	F 607	On 10/11/18 at approximately 3:00 pm, immediately upon notification from the state surveyor, the director of nursing (DON), the DON initiated an investigation. On 10/11/18 at approximately 3:15 pm the DON, corporate clinical facility consultant and corporate clinical director interviewed Nursing Assistant #1 The DON and corporate clinical director gave Nursing Assistant #1 a verbal re-education to include immediate interventions to protect Resident #3, immediate isolation of Nursing Assistant #8, immediate reporting to a supervisor, and proper way to report to the DON and administrator. On 10/11/18 at approximately 4pm, the treatment nurse completed a head-to-toe physical and emotional assessment of Resident #3. The assessment revealed no findings. On 10/11/18 at approximately 4pm, the DON contacted the police department. At approximately 5pm, the police arrived at the facility. The police officers obtain statements. On 10/11/18 at approximately 4:15pm, the DON contacted Resident #3□s physician and resident representative (RR). The physician gave no new orders. The RR did not answer. A message was left to please contact facility. On 10/11/18 at approximately 4:12 pm, the DON submitted an Initial Allegation Report to the North Carolina Complaint Intake and Health Care Personnel Investigation. On 10/12/18 at approximately 5:00pm, The RR returned the DON□s call. The DON told the RR about the Allegation.	

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F 607	Continued From page 63 #1 stated when he went onto the unit that morning the 11:00 PM to 7:00 AM NA #8 was not out on the floor and he assumed she was with a resident. He stated he was at the nurse's station and he heard Resident #3 start screaming, which was not normal for her, and immediately went to her room. NA #1 stated when he went into Resident #3's room she was in the bathroom with NA #8, who was yelling at her and was forcibly trying to make her sit down on the commode. He stated NA #8 was yelling at Resident #3 because she had been incontinent and had feces running down her legs and wouldn't sit down on the commode. NA #1 stated he told NA #8 it was time for her to leave the room because he thought she was being too rough with the resident and he would finish taking care of Resident #3 but she refused and told him she wasn't finished with her yet. He stated he left the room to get some gloves to go back in to help NA #8 and Medication Aide (Med Aide) #9 and Med Aide #10 were at the medication cart counting meds and he told them what was happening. NA #1 stated when he went back in Resident #3's bathroom NA #8 told him to leave. NA #1 stated he left Resident #3's room and went back out to the nurse's station and wrote a statement of what had happened and had Med Aide #9 write a statement of what she heard and took them to the sub-acute hall to Nurse #1 and reported the incident to her because she was the Nurse that was covering the Sparks Unit. He stated he didn't stay with Resident #3 and NA #8 because she told him to leave and he didn't know it was his responsibility to with them and he wanted to report the incident right away to the nurse. He further stated he was never interviewed by Administration about the incident and NA #8 continued to work on the Sparks Unit.	F 607	On 10/15/18 at approximately 5:40pm, The RR was called by the administrator, the incident was discussed. On 10/16/18, the administrator and DON met with Nursing Assistant #8 and obtained a written statement. After obtaining the written statement the administrator and DON told Nursing Assistant #8 that the investigation would not be complete until the sheriff□s department was finished and we would notify her of results of investigation. On 10/17/18, the sheriff□s department arrested Nursing Assistant #8. On 10/19/18, the administrator and DON met with Nurse #1, she was given a written warning for failing to assess and protect resident # 3. Also for not reporting immediately in person or by phone to the Administrator or DON that an allegation of abuse had been made. On 10/19/18, the administrator and DON met with Med Aide #9 and the Med Aide was given a verbal consultation and re-in serviced on proper procedure to protect resident at all times and proper notification to the Administrator and/ or Director of Nursing. On 10/19/18 the abuse/neglect re-education, including immediate actions and proper reporting, was 100% completed with all staff and contracted staff by Staff facilitator. On 10/17/18 at approximately 3:29 pm, the administrator submitted a 5-day report to the North Carolina Complaint Intake and Health Care Personnel Investigation. On 10/17/18 at approximately 4:30pm, the administrator called the RR with the	

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F 607	Continued From page 64 An interview conducted on 10/11/18 at 11:01 AM with Med Aide #9 revealed she worked as a Medication Aide on the Sparks Unit on 10/01/18 7:00 AM to 7:00 PM shift and was counting medications with the off-going Med Aide on the Sparks Unit around 7:00 AM. Med Aide #9 stated she heard Resident #3 screaming like she was in pain and then NA #1 came out of her room and told her NA #8 had Resident #3 in the bathroom and was being rough with her, trying to make her sit on the commode and yelling at her for having feces running down her legs because she had to clean her up. Med Aide #10 stated NA #1 told her he tried to get NA #8 to leave the room but she refused and he came out to get some gloves to go back in to help her. She stated she observed NA #1 go back into Resident #3's room and then come back out and he told her NA #8 told him to get out. Med Aide #9 stated she wrote a statement of what she heard, observed, and was told by NA #1 and he took the statements to Nurse #1 on the sub-acute hall to report the incident because she also was the nurse covering the Sparks Unit. Med Aide #9 further stated Resident #9 did not have behaviors of yelling or screaming like she was doing on the morning of 10/01/18. An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was on the sub-acute hall receiving report from the off-going 7:00 PM to 7:00 AM shift Nurse #5, when NA #1 came to her and told her there had been an incident of abuse with NA #8 and Resident #3 on the Sparks Unit and gave her 2 written statements. Nurse #1 stated she didn't go to the Sparks Unit and assess Resident #3 or talk to NA #8 and didn't report the incident to the Director of Nursing or the Administrator at that time because NA #8	F 607	sheriff□s department□s findings. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/11/18, the treatment nurse performed a head-to-toe skin audit on 100% of dementia unit residents to identify any residents with signs/symptoms of abuse. The audit identified no findings. On 10/11/18, the DON performed an audit on 100% of the staff schedule and staff assignment sheets. The audit was to identify any assignment where Nursing Assistant #8 had worked since the 10/1/18 incident date. The scheduling audit revealed six shifts. On 10/11/18 immediately after the audit, the DON reported the audit results to the administrator. The DON also instructed the quality improvement (QI) nurse not to schedule Nursing Assistant #8 to work. Also, the DON instructed the payroll staff, not to allow Nursing Assistant #8 past the facility front door entry, if Nursing Assistant #8 were to come to the facility. The DON attempted to contact Nursing Assistant #8 by telephone without success. The DON contacted the local authorities who came to the facility. On 10/17/18, the county sheriff□s department arrested Nursing Assistant #8. On 10/11/18, the DON instructed the Social Services Director (SSD) to perform Resident Abuse/Neglect Questionnaires on the residents. The questionnaires revealed no further allegations of abuse.	

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F 607	Continued From page 65 wasn't on her shift and she thought Nurse #5 should take care of the incident. She stated she did not discuss the incident with Nurse #5 regarding who was going to report it. Nurse #1 stated after she received report she took the witness statements and put them under the Administrators door and that was how she reported the incident. She stated she met NA #8 in the hall and asked her what happened and NA #8 told her it was all a misunderstanding so she didn't ask any more questions. Nurse #1 stated when there was an allegation of abuse it should be reported to the Administrator which was what she did by putting the witness statements under her door for review. Nurse #1 further stated she did not read the witness statements. An interview conducted on 10/11/18 2:15 PM with the Director of Nursing revealed she was never informed of the incident between Resident #3 and NA #8 until now. She stated she should have been informed immediately so an investigation could have been started and the 24-hour 5-day reports could have been sent to the state agency. An interview conducted on 10/11/18 at 2:18 PM with Nurse #5 revealed she was giving report to Nurse #1 on 10/01/18 when NA #1 came up and pulled Nurse #1 to the side and told her NA #8 and Resident #3 had an incident and he thought NA #8 had been verbally and physically abusive with Resident #3. Nurse #5 stated she didn't report the incident because NA #1 reported it to Nurse #1 and she assumed she would report the incident to the Director of Nursing and the Administrator. Nurse #5 further stated Resident #5 didn't have behaviors of yelling and screaming.	F 607	What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all RNs, LPNs, MAs, NAs, agency staff and contracted therapy personnel. The re-education covered: Abuse/Neglect and reporting. All staff, all departments, all contracted employees, including Nursing Assistant #1 and Nurse #1, are being instructed to keep resident safe at all times. If you suspect a resident is in harm□s way do not leave the resident. Nurses will document relevant information on the 24 hour report sheets and report relevant information to the on-coming shift nurse regarding abuse/neglect. All staff and contracted staff must follow the facility□s policy on abuse/neglect when staff become aware of actual or potential resident abuse/neglect. The administrator and DON must be notified immediately of all abuse/neglect allegation to ensure proper interventions are in place. The re-education was completed on 10/18/18 with all staff working; no RN, LPN, MA, NA, agency staff or contracted therapy personnel will be allowed to work, including Nursing Assistant #1 and Nurse #1, until the re-education is completed. The re-education is added to the new staff orientation for all staff and contracted therapy personnel On 10/11/18, the DON initiated in the morning inter-disciplinary team (IDT) meeting a review of all incidents, to	

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F 607	Continued From page 66 An interview conducted on 10/11/18 at 2:22 PM with the Administrator revealed no one had reported an abuse allegation to her regarding NA #8 and Resident #3 and there were no witness statements under her door on 10/01/18. She stated the surveyor's call was the first time she had heard about the incident. The Administrator stated NA #1 and Nurse #1 should have reported this incident to her immediately via phone if she wasn't in the building and the Director of Nursing NA #8 should have been escorted off the hall until an investigation was completed. She further stated it was her expectation for all abuse allegations to be reported to her and the Director of Nursing immediately. On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone. On 10/22/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/1/18 at approximately 7:00 am, Resident #3 was in the dementia unit bathroom. Resident #3 was sitting, clothed, in a wheelchair. Nursing Assistant #8 was assisting Resident #1 with ADL care. On 10/1/18 at approximately 7am, Nursing Assistant #1 observed Resident #3 in the dementia unit bathroom loudly screaming. Nursing Assistant #1 asked Nursing Assistant #8 "what she needed". Nursing Assistant #8 replied	F 607	include abuse/neglect. The review included verifying that abuse/neglect allegations were reported to the administrator and DON, the offender was immediately removed from resident areas, an assessment was completed immediately post-incident, that the physician/nurse practitioner was notified of all abuse/neglect allegations with all relevant information provided. The resident representative was notified. That the authorities were contacted. On 10/19/18 An in-service was completed with Nurse #1 about assessing a resident immediately if an allegation of abuse is made. In serviced by Director of Nursing. On 10/19/18, The Administrative nursing staff will monitor direct care of 10 % of resident□s daily X 4 weeks, then weekly X 4 weeks, then monthly for 6 months starting 10/19/2018 to insure no abuse is occurring. On 10/19/18, The Social Worker will do weekly rounds asking interview able residents if staff are being good to the residents for 6 months. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed) Beginning 10/11/18, the DON, QI nurse, and/or staff facilitator will review the 24 hour PCC progress notes. Beginning 10/11/18, the 24 hour report sheet review findings will be reconciled with the 24 hour PCC progress note review findings to ensure all allegations of abuse/neglect	

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F 607	Continued From page 67 "wipes now". Nursing Assistant #1 then went to the linen room and obtained wipes. On 10/1/18 at approximately 7:15am Nursing Assistant #1 states that he saw Nursing Assistant #8 take residents hand and push her onto the toilet and yelled at her. On 10/1/18, at approximately 7:35 am Nursing Assistant #1 reported the observations of Nursing Assistant #8's interactions with Resident #3 in the bathroom to Nurse #1. Nurse #1 collected statements from Medication Aide #9 and Nursing Assistant #1. Nurse #1 placed the statements under the administrator's door at approximately 7 pm before leaving work. The administrator never received the statements from Medication Aide #9 or Nursing Assistant #1. On 10/1/18 Nurse #1 did not assess resident after allegation of abuse was made. On 10/11/18 at approximately 3:00 pm, immediately upon notification from the state surveyor, the director of nursing (DON), the DON initiated an investigation. On 10/11/18 at approximately 3:15 pm the DON, corporate clinical facility consultant and corporate clinical director interviewed Nursing Assistant #1 The DON and corporate clinical director gave Nursing Assistant #1 a verbal re-education to include immediate interventions to protect Resident #3, immediate isolation of Nursing Assistant #8, immediate reporting to a supervisor, and proper way to report to the DON and administrator. On 10/11/18 at approximately 4pm, the treatment nurse completed a head-to-toe physical and emotional assessment of Resident #3. The assessment revealed no findings. On 10/11/18 at approximately 4pm, the DON contacted the police department. At approximately 5pm, the police arrived at the	F 607	have documented assessments and reports to the administrator, DON, physician/nurse practitioner, resident representative, and authorities. These reviews and reconciliations will be completed (5) five times a week for a period of (6)six months. On 10/19/2018, The Administrative nursing staff will monitor direct care of 10 % of resident□s daily X 4 weeks, then weekly X 4 weeks, then monthly for 6 months starting 10/19/2018 to insure no abuse is occurring. On 10/19/18, The Social Worker will do weekly rounds times 6 months asking interview able residents if staff have abused/neglected them. On 10/11/18, the DON and corporate clinical director notified the daily quality assurance and performance improvement (QAPI) team. The daily QAPI team□s role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team also making recommendations for revisions as needed. The daily QAPI review findings will be brought to the next quarterly QAPI meeting for additional review and recommendations. Beginning 10/11/18, the administrator will be responsible for implementing and monitoring corrective measures.	

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facility. The police officers obtain statements.
On 10/11/18 at approximately 4:15pm, the DON contacted Resident #3's physician and resident representative (RR). The physician gave no new orders. The RR did not answer. A message was left to please contact facility.
On 10/11/18 at approximately 4:12 pm, the DON submitted an Initial Allegation Report to the North Carolina Complaint Intake and Health Care Personnel Investigation.
On 10/12/18 at approximately 5:00pm, The RR returned the DON's call. The DON told the RR about the Allegation.
On 10/15/18 at approximately 5:40pm, The RR was called by the administrator, the incident was discussed.
On 10/16/18, the administrator and DON met with Nursing Assistant #8 and obtained a written statement. After obtaining the written statement the administrator and DON told Nursing Assistant #8 that the investigation would not be complete until the sheriff's department was finished and we would notify her of results of investigation.
On 10/17/18, the sheriff's department arrested Nursing Assistant #8.
On 10/19/18, the administrator and DON met with Nurse #1, she was given a written warning for failing to assess and protect resident # 3. Also for not reporting immediately in person or by phone to the Administrator or DON that an allegation of abuse had been made.
On 10/19/18, the administrator and DON met with Med Aide #9 and the Med Aide was given a verbal consultation and re-in serviced on proper procedure to protect resident at all times and proper notification to the Administrator and/ or Director of Nursing.
On 10/19/18 the abuse/neglect re-education, including immediate actions and proper reporting,

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was 100% completed with all staff and contracted staff by Staff facilitator.
On 10/17/18 at approximately 3:29 pm, the administrator submitted a 5-day report to the North Carolina Complaint Intake and Health Care Personnel Investigation.
On 10/17/18 at approximately 4:30pm, the administrator called the RR with the sheriff's department's findings.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/11/18, the treatment nurse performed a head-to-toe skin audit on 100% of dementia unit residents to identify any residents with signs/symptoms of abuse. The audit identified no findings.
On 10/11/18, the DON performed an audit on 100% of the staff schedule and staff assignment sheets. The audit was to identify any assignment where Nursing Assistant #8 had worked since the 10/1/18 incident date. The scheduling audit revealed six shifts. On 10/11/18 immediately after the audit, the DON reported the audit results to the administrator. The DON also instructed the quality improvement (QI) nurse not to schedule Nursing Assistant #8 to work. Also, the DON instructed the payroll staff, not to allow Nursing Assistant #8 past the facility front door entry, if Nursing Assistant #8 were to come to the facility. The DON attempted to contact Nursing Assistant #8 by telephone without success. The DON contacted the local authorities who came to the facility. On 10/17/18, the county sheriff's department arrested Nursing Assistant #8.
On 10/11/18, the DON instructed the Social Services Director (SSD) to perform Resident Abuse/Neglect Questionnaires on the residents.

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F 607	Continued From page 70 The questionnaires revealed no further allegations of abuse. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all RNs, LPNs, MAs, NAs, and contracted therapy personnel. The re-education covered: Abuse/Neglect and reporting. All staff, all departments, all contracted employees, including Nursing Assistant #1 and Nurse #1, are being instructed to keep resident safe at all times. If you suspect a resident is in harm's way do not leave the resident. Nurses will document relevant information on the 24 hour report sheets and report relevant information to the on-coming shift nurse regarding abuse/neglect. All staff and contracted staff must follow the facility's policy on abuse/neglect when staff become aware of actual or potential resident abuse/neglect. The administrator and DON must be notified immediately of all abuse/neglect allegation to ensure proper interventions are in place. The re-education was completed on 10/18/18 with all staff working; no RN, LPN, MA, NA, or contracted therapy personnel will be allowed to work, including Nursing Assistant #1 and Nurse #1, until the re-education is completed. The re-education is added to the new staff orientation for all staff and contracted therapy personnel On 10/11/18, the DON initiated in the morning inter-disciplinary team (IDT) meeting a review of all incidents, to include abuse/neglect. The review included verifying that abuse/neglect allegations were reported to the administrator and DON, the offender was immediately removed	F 607		

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from resident areas, an assessment was completed immediately post-incident, that the physician/nurse practitioner was notified of all abuse/neglect allegations with all relevant information provided. The resident representative was notified. That the authorities were contacted.
On 10/19/18 An in-service was completed with Nurse #1 about assessing a resident immediately if an allegation of abuse is made. In serviced by Director of Nursing.
On 10/19/18, The Administrative nursing staff will monitor direct care of 10 % of resident's daily X 4 weeks, then weekly X 4 weeks, then monthly for 6 months starting 10/19/2018 to insure no abuse is occurring.
On 10/19/18, The Social Worker will do weekly rounds asking interview able residents if staff are being good to the residents for 6 months.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning 10/11/18, the DON, QI nurse, and/or staff facilitator will review the 24 hour PCC progress notes. Beginning 10/11/18, the 24 hour report sheet review findings will be reconciled with the 24 hour PCC progress note review findings to ensure all allegations of abuse/neglect have documented assessments and reports to the administrator, DON, physician/nurse practitioner, resident representative, and authorities. These reviews and reconciliations will be completed five times each week for a period of six months.
On 10/19/2018, The Administrative nursing staff will monitor direct care of 10 % of resident's daily X 4 weeks, then weekly X 4 weeks, then monthly

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F 607	Continued From page 72 for 6 months starting 10/19/2018 to insure no abuse is occurring. On 10/19/18, The Social Worker will do weekly rounds asking interview able residents if staff are being good to the residents for 6 months. On 10/11/18, the DON and corporate clinical director notified the daily quality assurance and performance improvement (QAPI) team. The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team also making recommendations for revisions as needed. The daily QAPI review findings will be brought to the next quarterly QAPI meeting for additional review and recommendations. Beginning 10/11/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley alleges compliance of removal of IJ as of 10/22/18. On 10/23/18 facility staff were interviewed and demonstrated they had been trained on the topics of what to do if a resident was being abused, how to report abuse and neglect, and what to do for staff burn out. Immediate jeopardy was removed effective 10/22/18.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		12/5/18

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F 609	Continued From page 73 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to submit a 24-hour and 5-day report to the State Agency for 1 of 3 residents reviewed for abuse (Resident #3). The findings included: Resident #3 was admitted to the facility on 03/30/18 with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 07/06/18 revealed Resident #3 was severely cognitively intact. The MDS further revealed Resident #3 had delusions, physical and verbal behaviors toward others, rejection of care	F 609	F 609 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/11/18 at approximately 4:12 pm, the director of nursing (DON) submitted an Initial Allegation Report to the North Carolina Complaint Intake and Health Care Personnel Investigation. On 10/17/18 at approximately 3:29 pm, the administrator submitted a 5-day report to the North Carolina Complaint Intake and Health Care Personnel Investigation.	

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F 609	Continued From page 74 and wandering 1 to 3 days during the assessment period. Review of the nurse's notes from 09/30/18 through 10/12/18 revealed no documentation of Nurse Aide (NA) #1 or NA #9 having concerns that NA #8 had been physically or verbally abusive to Resident #3 on the morning of 10/01/18. Review of the facility incident reports from 09/30/18 through 10/12/18 revealed there was no incident report for alleged physical/verbal abuse of Resident #3 by NA #8 on 10/01/18. An interview conducted on 10/11/18 at 10:36 AM with NA #1 revealed he worked the 7:00 AM to 3:00 PM shift on the Sparks Unit on 10/01/18. NA #1 stated when he went onto the unit that morning the 11:00 PM to 7:00 AM NA #8 was not out on the floor and he assumed she was with a resident. He stated he was at the nurse's station and he heard Resident #3 start screaming, which was not normal for her, and immediately went to her room. NA #1 stated when he went into Resident #3's room she was in the bathroom with NA #8, who was yelling at her and was forcibly trying to make her sit down on the commode. He stated NA #8 was yelling at Resident #3 because she had been incontinent and had feces running down her legs and wouldn't sit down on the commode. NA #1 stated he told NA #8 it was time for her to leave the room because he thought she was being too rough with the resident and he would finish taking care of Resident #3 but she refused and told him she wasn't finished with her yet. He stated he left the room to get some gloves to go back in to help NA #8 and Medication Aide (Med Aide) #9 and Med Aide #10 were at the	F 609	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/11/18, the DON and corporate consultants reviewed 90 days of incident reports to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The review did not identify any other unreported allegations of abuse/neglect. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 10/19/18, the staff facilitator completed 100% in-servicing on abuse/neglect, including immediate actions and proper reporting, with all facility staff, agency staff, and contracted therapy staff. The in-service covered: Abuse/Neglect and reporting. All staff, all departments, all agency staff, all contracted employees, were instructed to keep residents safe at all times. If you suspect a resident is in harm's way do not	

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F 609	Continued From page 75 medication cart counting meds and he told them what was happening. NA #1 stated when he went back in Resident #3's bathroom NA #8 told him to leave. NA #1 stated he left Resident #3's room and went back out to the nurse's station and wrote a statement of what had happened and had Med Aide #9 write a statement of what she heard and took them to the sub-acute hall to Nurse #1 and reported the incident to her because she was the Nurse that was covering the Sparks Unit. He stated he didn't stay with Resident #3 and NA #8 because she told him to leave and he didn't know it was his responsibility to with them and he wanted to report the incident right away to the nurse. He further stated he was never interviewed by Administration about the incident and NA #8 continued to work on the Sparks Unit. An interview conducted on 10/11/18 at 11:01 AM with Med Aide #9 revealed she worked as a Medication Aide on the Sparks Unit on 10/01/18 7:00 AM to 7:00 PM shift and was counting medications with the off-going Med Aide on the Sparks Unit around 7:00 AM. Med Aide #9 stated she heard Resident #3 screaming like she was in pain and then NA #1 came out of her room and told her NA #8 had Resident #3 in the bathroom and was being rough with her, trying to make her sit on the commode and yelling at her for having feces running down her legs because she had to clean her up. Med Aide #10 stated NA #1 told her he tried to get NA #8 to leave the room but she refused and he came out to get some gloves to go back in to help her. She stated she observed NA #1 go back into Resident #3's room and then come back out and he told her NA #8 told him to get out. Med Aide #9 stated she wrote a statement of what she heard, observed, and was told by NA #1 and he took the statements to	F 609	leave the resident. Nurses will document relevant information on the 24 hour report sheets and report relevant information to the on-coming shift nurse regarding abuse/neglect. All staff, all agency staff, and contracted staff must follow the facility's policy on abuse/neglect when staff become aware of actual or potential resident abuse/neglect. The administrator and DON must be notified immediately of all abuse/neglect allegations to ensure proper 24-hour and 5-day reports to the State Agency are submitted and other authorities are notified as appropriate. The in-servicing was completed 11/25/18. After 10/19/18, no facility staff, agency staff, or contracted therapy staff was allowed to work until they completed the in-service. The in-service was added to the new employee orientation for all facility staff, agency staff, and contracted therapy staff. On 10/11/18, the DON initiated in the morning inter-disciplinary team (IDT) meeting a review of all incidents, to include abuse/neglect. The review included verifying that abuse/neglect allegations were reported to the administrator and DON, the physician and resident representative were notified, the authorities were contacted as appropriate, and the 24-hour and 5-day report to the State Agency were submitted timely. How the facility plans to monitor its performance to make sure solutions are sustained	

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F 609	Continued From page 76 Nurse #1 on the sub-acute hall to report the incident because she also was the nurse covering the Sparks Unit. Med Aide #9 further stated Resident #3 did not have behaviors of yelling or screaming like she was doing on the morning of 10/01/18. An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was on the sub-acute hall receiving report from the off-going 7:00 PM to 7:00 AM shift Nurse #5, when NA #1 came to her and told her there had been an incident of abuse with NA #8 and Resident #3 on the Sparks Unit and gave her 2 written statements. Nurse #1 stated she didn't go to the Sparks Unit and assess Resident #3 or talk to NA #8 and didn't report the incident to the Director of Nursing or the Administrator at that time because NA #8 wasn't on her shift and she thought Nurse #5 should take care of the incident. She stated she did not discuss the incident with Nurse #5 regarding who was going to report it. Nurse #1 stated after she received report she took the witness statements and put them under the Administrators door and that was how she reported the incident. She stated she met NA #8 in the hall and asked her what happened and NA #8 told her it was all a misunderstanding so she didn't ask any more questions. Nurse #1 stated when there was an allegation of abuse it should be reported to the Administrator which was what she did by putting the witness statements under her door for review. Nurse #1 further stated she did not read the witness statements. An interview conducted with the Director of Nursing revealed she was never informed of the incident between Resident #3 and NA #8 until now. She stated she should have been informed	F 609	Beginning 10/11/18, the DON, QI nurse, and/or staff facilitator will review the 24 hour PCC progress notes. Beginning 10/11/18, the 24 hour report sheet review findings will be reconciled with the 24 hour PCC progress note review findings to ensure all allegations of abuse/neglect have documented assessments and reports to the administrator, DON, physician/nurse practitioner, and resident representative. These reviews and reconciliations will be completed five times each week for a period of six months. Weekly, the administrator, corporate consultant, and/or vice president of operations will review investigative files to ensure the State Agency and other authorities are notified as appropriate. Beginning 11/25/18, the administrator will present the results of the audits and reviews to the monthly QI committee for four (4) months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The administrator will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) Committee for further recommendations and oversight.	

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F 609	Continued From page 77 immediately so an investigation could have been started and the 24-hour 5-day reports could have been sent to the state agency. An interview conducted on 10/11/18 at 2:18 PM with Nurse #5 revealed she was giving report to Nurse #1 on 10/01/18 when NA #1 came up and pulled Nurse #1 to the side and told her NA #8 and Resident #3 had an incident and he thought NA #8 had been verbally and physically abusive with Resident #3. Nurse #5 stated she didn't report the incident because NA #1 reported it to Nurse #1 and she assumed she would report the incident to the Director of Nursing and the Administrator. Nurse #5 further stated Resident #5 didn't have behaviors of yelling and screaming. An interview conducted on 10/11/18 at 2:22 PM with the Administrator revealed no one had reported an abuse allegation to her regarding NA #8 and Resident #3 and there were no witness statements under her door on 10/01/18. She stated the surveyor's call was the first time she had heard about the incident. The Administrator stated NA #1 and Nurse #1 should have reported this incident to her immediately via phone if she wasn't in the building and the Director of Nursing NA #8 should have been escorted off the hall until an investigation was completed. She further stated it was her expectation for all abuse allegations to be reported to her and the Director of Nursing immediately.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		12/5/18

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F 656	Continued From page 78 §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 - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 79 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow the care plan for 1 of 4 residents reviewed for falls (Resident #20). The findings included: Resident #20 was admitted to the facility on 09/17/18 with diagnoses included hip fracture repair, high blood pressure, atrial fibrillation, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of the admission nursing assessment dated 09/17/18 revealed Resident #20 was alert to person, place and time. Review of the care plan dated 09/18/18 revealed Resident #20 was at risk for falls/actual falls, injury, multiple risk factors related to deconditioning, incontinence, impaired balance and impaired mobility. The goal was for Resident #20 to be free of falls, and not sustain serious injury through the next review. The interventions included having the resident's bed in the lowest position. An interview conducted on 10/10/18 at 11:07 AM with Nurse Aide (NA) #1 revealed he had just started his shift and was doing his first set of rounds when he heard Resident #20 screaming around 3:45 PM. He stated he went to her room and she was lying on her right side with her right arm underneath her and her head lying on the floor facing the bed. NA #1 stated Resident #20 was bleeding from skin tears to both sides of her body. He stated the bed was in the high position	F 656	F 656 How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/11/18 - 10/19/18, the director of nursing (DON) and corporate consultant reviewed Resident #20's progress notes and care plan, witness statements, and incident report during the post-accident investigation. The review revealed the care plan for having the bed in low position was not followed immediately prior to Resident #20's fall from the bed. Resident #20 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/11/18 – 11/02/18, the DON, QI nurse, and corporate consultant audited 100% of nurse progress notes for the past 60 days of all residents looking for any documented incidents/accidents. The audit revealed other incidents accidents relating to nursing staff failing to follow the care plan for falls. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur: On 10/11/18, the QI nurse initiated a 100% in-service with all registered nurses (RNs), licensed practical nurses (LPNs),	

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F 656	Continued From page 80	F 656		

and there were no fall mats on the floor. NA #1 stated he called a code green for help and Resident #20 was yelling out in pain. He stated NA #2, NA #3, and Nurse #1 came into the room. NA #1 stated Nurse #1 assessed the resident and then the 4 of them moved Resident #20 back to bed using a sheet underneath her. NA #1 stated he did not ask and did not hear Nurse #1 ask Resident #20 if she hit her head on the floor but her head was laying on the floor when he found her.

An interview conducted on 10/10/18 at 12:05 PM with NA #3 revealed she helped NA #2 transfer Resident #20 from the chair to the bed on 09/22/18 close to shift change around 2:45 PM and then went back to her hall. She stated she heard the code green around 4:00 PM and went to Resident #20's room. She stated Resident #20 was lying on the floor with her head on the floor facing her bed that was in the high position. NA #3 stated she helped transfer Resident #20 back to bed and then went back to her hall. She further stated Resident #20 was yelling out in pain before, during and after the transfer.

An interview conducted on 10/11/18 at 10:30 AM with NA #2 revealed he had transferred Resident #20 from the chair to the bed just before shift change on 09/22/18 and he was at the nurse's desk and heard the code green called. He stated he went to Resident #20's room and she was lying on the floor on her right side with her right arm twisted underneath her and her head was lying on the floor with the bed in the high position. He stated she was yelling out in pain and was bleeding from some skin tears. NA #2 stated he helped Nurse #1, NA #1 and NA #3 transfer Resident #20 back to bed and then left the room.

nursing assistants (NAs), and agency staff. The DON must be notified of all falls with injuries within 2 hours of the incident to discuss whether or not the care plan was followed and ensure any new intervention is appropriate.
On 10/19/18, the DON and staff facilitator (SF) initiated multiple in-services for 100% of appropriate staff to include registered nurses (RNs), licensed practical nurses (LPNs), NAs, geriatric care assistants, agency staff, housekeeping, laundry, dietary, therapy, and department heads. The in-services included education on resident safety (as indicated in the care plan). After 10/19/18, no facility nursing staff, nursing agency staff, or contracted therapy staff will be allowed to work until the in-services are completed. The in-serviced with be added to new staff orientation, including agency and contracted staff.
On 10/19/18, the DON, QI nurse and SF nurse began five day per week reviews of the nursing 24-hour report sheets and progress notes looking for any new orders, incident/accidents, and/or new safety measures added, to help ensure the nursing staff, agency staff, and contracted therapy staff are following residents' care plans.
On 10/22/18, the administrator, department heads, and corporate facility consultants began a process of root cause analysis using "5-Whys", during the interdisciplinary team (IDT) meeting to help ensure the residents' care plans are appropriate, updated, and are being followed by the facility staff, agency staff,

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F 656	Continued From page 81 An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was called to Resident #20's room by a code green and when she went in the room Resident #20 was lying on her left side with her head on the ground. She stated she didn't remember what position the bed was in. Nurse #1 stated Resident #20 was yelling out in pain while she assessed her but she had good range of motion of all extremities and multiple skin tears. Nurse #1 stated Resident #20's Responsible Party (RP) came in during the assessment and felt like the resident had broken her right shoulder/arm and wanted her sent out to the hospital. She stated she told the RP they could have an x-ray done at the facility and it would be quicker than going to the hospital and he was good with doing it that way. Nurse #1 stated she didn't remember calling the on-call provider and thought the on-coming nurse had called them but after reviewing her nurse's notes she stated, "I guess I probably called the physician and got the order for the x-ray of her shoulder." She stated she would not have told the physician Resident #20 was on Coumadin after the unwitnessed fall because she wouldn't have sent Resident #20 out, she would have started neuro checks and monitored her condition. Nurse #1 stated she did not start neuro checks but reported off to the on-coming nurse about the fall. She stated she did have NA #1 obtain vital signs. Nurse #1 further stated she was Resident #20's nurse on 09/23/18 on the 7:00 AM to 7:00 PM shift and the resident was alert, and talking during the morning of 09/23/18. Nurse #1 stated Resident #20's RP was at her bedside most of the morning and around 10:00 AM she was on her way to Resident #20's room and the NA yelled for her. Nurse #1 explained when she got to the	F 656	and contracted therapy staff. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when correction action will be competed). On 10/19/18, the administrator initiated multiple audit tools which will be completed by the department heads (DON, QI nurse, SF, social worker, dietary manager, activities, activity director, and weekend manager-on-duty). The audits will include supervision observations utilizing the Administrative Rounds tool to ensure residents are free of accident hazards, have adequate supervision and safe devices to use which are all part of the residents' care plans. On 10/26/18, the administrator began working with the QIO to improve effective leadership and management and seek guidance on how to make changes that improve the facility's nursing staff, agency staff, and contracted therapy staff implementation of resident care plans, including fall care plans. Beginning 10/19/18, the DON, and QI nurse will present the in-services, supervision observations, and audit trends to the IDT and monthly QI committee for (6) six months. The IDT and QI committee will help ensure the facility is following residents' care plans, focusing on care plans for falls. The administrator and/or DON will present the daily IDT and monthly QI committee recommendations to the quarterly QAPI committee for	

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F 656	Continued From page 82	F 656		

room and assessed Resident #20 she had stopped breathing. She stated she checked her code status and she was a DNR so she didn't initiate CPR.

Review of the Incident note written by Nurse #1 and dated 09/22/18 6:44 PM revealed Resident #20 had multiple skin tears and they were cleaned and treated. The right shoulder was swollen and Responsible Party (RP) felt it was broken and wanted the resident to go to the emergency room. The note revealed Nurse #1 didn't feel her arm/shoulder was broken because she had range of motion and was using it, not in pain while moving. The Physician was contacted. An order for an x-ray was called into the technician and was done at 6:00 PM in the facility.

Review of the physician order's dated 09/22/18 at 4:00 PM an order was written for Resident #20 by Nurse #1 and signed by the Physician for an x-ray of right shoulder to rule out injury from a fall.

Review of the x-ray right shoulder results dated 09/22/18 revealed there was no evidence of an acute fracture or dislocation.

Two attempts were unsuccessful to interview Nurse #2 via phone on 10/11/18 at 2:00 PM and 10/12/18 at 8:40 AM.

Review of the nurse's note dated 09/23/18 at 12:45 PM written by Nurse #1 revealed Resident #20's RP had been at her bedside since after breakfast. The NA went in to get Resident #20's vital signs and called Nurse #1 to the room. The NA stated when she put the blood pressure cuff on the resident she looked like she stopped

additional recommendations for monitoring and continued compliance.

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F 656	Continued From page 83 breathing. The note revealed Nurse #1 stated at the same time Resident #20's RP walked up to her and told her Resident #20's oxygen wasn't working. Nurse #1 stated when she got to the room Resident #20 was lying in bed without her oxygen on and she picked up the oxygen tubing and held it to her ear and then to the RP's ear to show him it was working. The note revealed Nurse #1 told the RP she would send Resident #20 to the emergency room for evaluation but she stopped breathing. Resident #20 was a Do Not Resuscitate (DNR) and Cardio Pulmonary Resuscitation (CPR) was not initiated. An interview conducted on 10/11/18 at 3:04 PM with the Director of Nursing revealed it was her expectation for staff to follow the care plan.	F 656		
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; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide care to ensure hands and fingernails were clean and oral care was completed for 1 of 7 sampled dependent residents reviewed for activities of daily living skills. (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/09/18. His diagnoses included Parkinson's Disease, unstable angina, convulsions, major	F 677	F677 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency-the facility failed to provide care to ensure hands and fingernails were clean and oral care was completed- was staff failure to follow established procedure.	12/5/18

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F 677	Continued From page 84 depressive disorder, anxiety, and chronic kidney disease and dysphagia. The resident care guide initiated on 07/09/18, used by nurse aides for care guidance, included an update on 07/11/18, to provide mouth care after meals. The admission Minimum Data Set dated 07/16/18 coded him with severely impaired cognitive abilities, requiring extensive assistance with most activities of daily livings skills including hygiene and bathing. He was coded as having no behaviors. The Activity of daily living Care Area Assessment dated 07/19/18 stated Resident #1 needed staff assistance and he was working with therapy. The care plan for hygiene initiated on 07/17/18 had the goal for him to be neat, clean and odor free and he would maintain good oral hygiene. The interventions included to provide constant supervision with physical assistance, i.e. comb hair, shave and provide assistance with set up of oral/dental supplies. The care plan for bathing initiated 07/16/18 had the goal for him to be neat, clean and odor free. The interventions include for staff to ensure hair is washed and nails are manicured on bathing day. Review of the paper medical chart revealed a Personal Swallowing Plan dated 07/24/18. The instructions included to "please provide oral care after all meals." On 10/09/18 at 9:57 AM, Resident #1 was	F 677	On 10/9/18 at 9:57 AM, Resident #1 was observed with dark smears on his right forefinger and his left thumbnail had dark debris. On 10/9/18, The NA cleaned Resident□s #1 was provided hand and nail care immediately by staff. 10/19/18, the director of nursing (DON), quality improvement nurse (QI), unit manager, and staff facilitator (SF) began monitoring of 10 residents for direct care of the residents daily for four weeks, then weekly for four weeks, then monthly for 6 months. On 11/7/18, activities director (AD), skilled rehabilitation services, and the administrative nursing team implemented weekly nail care program. The new program includes 1.) The activity program includes nail care during games. 2.) The therapy department initiated nail care as an occupational treatment regimen for fine motor skills. On 11/7/18, SF initiated a 100% in-service with all licensed nurses, nursing assistants (NA□s)and Agency staff to include expected daily care or ADLs (activities of daily living) must be provided to All residents routinely and as needed to include bathing or showers, mouth care and nail care. No licensed nurse or nursing assistant (NA), or Agency staff will be allowed to work after 11/19/18 until the in-service completed. This in-service will be added to the orientation process for all new licensed nurses and NAs and agency staff. On 11/8/18, the DON, QI, unit manager,	

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F 677	Continued From page 85 observed with dark smears on his right forefinger and his left thumb nail had dark debris under it. On 10/09/18 at 11:05 PM, Nurse Aide #4 stated she had not done mouth care on Resident #1. On 10/09/18 at 1:12 PM Resident #1 was observed to still have soiled fingers and a dirty thumb nail. Both hands had food debris. NA #4 then moved him and set him up with the noon meal without any hand washing. Resident #1 still had soiled hands and debris under his thumb nail when observed on 10/09/18 at 3:02 PM. On 10/09/18 at 4:46 PM, NA #4 stated during interview that she had not done any mouth care on Resident #1 this date. She also stated she did not do hand care and did not notice dirty nails or hands. She stated there was not enough staff scheduled and working to get all the necessary care completed. Interview with the Director of Nursing on 10/10/18 at 6:33 PM revealed she expected hand and mouth care to be completed. She stated she noticed his thumb nail this morning needed attention.	F 677	and SF completed a 100% audit of nail and oral care on the residents. The audit resulted in several residents were in need of nail and/or oral care. The DON, SF and/or QI nurse will track and trend the results and re-train and/or initiate counseling for nursing staff as indicated. The DON will hare share the results of audits with the QI committee monthly for 3 months then quarterly thereafter. The monthly QI committee will review the results of the resident care audit tool for 3 months. The DON and/or QI nurse will review the results of the resident care audit tool for determine the need for and/or frequency of continued monitoring and make recommendations. The administrator and/or DON will present the findings of the monthly QI committee to the quarterly executive QAPI committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of nursing is responsible for implementing this plan of correction.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		12/5/18

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F 684	Continued From page 86 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician and Medical Examiner interviews, the facility failed to perform neurological checks per the facility's neurological guide after a fall from the bed to the floor and failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner. This affected one of three sampled residents reviewed for assessment following an acute episode. The failure of the facility to assess Resident #20's neurological status per the facility's protocol and communicate an unwitnessed fall from the bed to the floor and blood thinner use to the physician resulted in the high likelihood of serious injury or death (Resident #20). Immediate Jeopardy began on 09/22/18 for Resident # 20 when the facility failed to perform neurological checks per the facility's neurological guide after a fall from the bed to the floor and failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner. Immediate Jeopardy was removed on 10/11/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. Based on observations, record review, resident,	F 684	F 684 How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 9/12/18, Nurse #3 rechecked Resident #2's blood glucose with a result of "HI". Nurse #3 contacted the nurse practitioner. The nurse practitioner gave a verbal order to Nurse #3 for Resident # 2 to be sent to emergency room. Resident # 2 was transferred to the hospital emergency room by emergency medical services for evaluation of elevated blood glucose. On 10/11/18 - 10/19/18, the director of nursing (DON) and corporate consultant reviewed Resident #20's progress notes and care plan, witness statements, and incident report during the post-accident investigation. The review revealed the care plan for having the bed in low position was not followed immediately prior to Resident #20's fall from the bed. Resident #20 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice	

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F 684	Continued From page 87 staff, and Nurse Practitioner interviews the facility failed to administer insulin per physician order's which caused the resident to be sent out to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed with insulin dependent diabetes (Resident #2). Immediate Jeopardy began on 09/11/18 for Resident # 2 when Nurse #4 did not administer insulin per physician's order which resulted in Resident #2 developing DKA. Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: 1. Review of the Neuro Checks Guide located at each nurse's station revealed neuro checks should be done as follows: every thirty minutes for 4 hours, every hour for 4 hours and every shift for 3 days once initiated. Resident #20 was admitted to the facility on 09/17/18 with diagnoses included hip fracture repair, high blood pressure, atrial fibrillation, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of the admission nursing assessment dated 09/17/18 revealed Resident #20 was alert to person, place and time.	F 684	On 10/19/18, the DON and unit manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders. On 10/22/18 the unit manager contacted the physician regarding undocumented doses of insulin. The physician gave no new orders. Multiple nurses failed to either administer insulin as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facility at multiple times during the day. The medication errors occurred due to multiple nurses' failure to follow the medication administration policy. On 10/19/18, the DON and unit manager audited to ensure all residents on insulin have the insulin available in the facility. All residents had insulin available to match order. On 10/11/18 – 11/02/18, the DON, QI nurse, and corporate consultant audited 100% of nurse progress notes for the past 60 days of all residents looking for any documented incidents/ accidents. The audit revealed other incidents accidents relating to nursing staff failing to follow the care plan for falls. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur	

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F 684	Continued From page 88 Review of the care plan dated 09/18/18 revealed Resident #20 was at risk for falls/actual falls, injury, multiple risk factors related to deconditioning, incontinence, impaired balance and impaired mobility. The goal was for Resident #20 to be free of falls, and not sustain serious injury through the next review. The interventions included having the resident's bed in the lowest position. Review of the On-Call Provider sheet with a Revision Date of 03/05/15 located at each nurse's station revealed the following when calling an on-call provider: Please have the following information ready before calling which included current medications, if reporting a change in condition, have a description of the signs and symptoms associated with the change, a brief synopsis, relevant past history, and incident report. Review of the physician orders for Resident #20 revealed: On 09/17/18 Coumadin, a blood thinner, 5 milligrams (mg) once a day for atrial fibrillation. An interview conducted on 10/10/18 at 11:07 AM with Nurse Aide (NA) #1 revealed he had just started his shift and was doing his first set of rounds when he heard Resident #20 screaming around 3:45 PM. He stated he went to her room and she was lying on her right side with her right arm underneath her and her head lying on the floor facing the bed. NA #1 stated Resident #20 was bleeding from skin tears to both sides of her body. He stated the bed was in the high position and there were no fall mats on the floor. NA #1 stated he called a code green for help and Resident #20 was yelling out in pain. He stated	F 684	On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing 100% of residents on insulin once daily 5 times weekly x 12 weeks to ensure insulin is available for administration as ordered. This audit will be documented on the insulin audit tool. On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing 100% of residents on insulin. The auditing will be completed once daily 5 times weekly x 12 weeks to ensure insulin was administered as ordered. This audit will be documented on the insulin audit tool. On 10/20/18, the DON, QI nurse, SF, and/or administrator began reviewing all referrals to ensure if a potential resident would be on insulin and the medication is available prior to resident admission. This audit will be documented on the insulin referral audit tool. This audit will be completed on each referral for 12 weeks. On 10/11/18, the QI nurse initiated a 100% in-service with all registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), and agency staff. The DON must be notified of all falls with injuries within 2 hours of the incident to discuss whether or not the care plan was followed and ensure any new intervention is appropriate. On 10/19/18, the DON and staff facilitator (SF) initiated multiple in-services for 100% of appropriate staff to include registered nurses (RNs), licensed practical nurses (LPNs), NAs, geriatric care assistants, agency staff, housekeeping, laundry,	

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F 684	Continued From page 89 NA #2, NA #3, and Nurse #1 came into the room. NA #1 stated Nurse #1 assessed the resident and then the 4 of them moved Resident #20 back to bed using a sheet underneath her. NA #1 stated he did not ask and did not hear Nurse #1 ask Resident #20 if she hit her head on the floor but her head was laying on the floor when he found her. An interview conducted on 10/10/18 at 12:05 PM with NA #3 revealed she helped NA #2 transfer Resident #20 from the chair to the bed on 09/22/18 close to shift change around 2:45 PM and then went back to her hall. She stated she heard the code green around 4:00 PM and went to Resident #20's room. She stated Resident #20 was lying on the floor with her head on the floor facing her bed that was in the high position. NA #3 stated she helped transfer Resident #20 back to bed and then went back to her hall. She further stated Resident #20 was yelling out in pain before, during and after the transfer. An interview conducted on 10/11/18 at 10:30 AM with NA #2 revealed he had transferred Resident #20 from the chair to the bed just before shift change on 09/22/18 and he was at the nurse's desk and heard the code green called. He stated he went to Resident #20's room and she was lying on the floor on her right side with her right arm twisted underneath her and her head was lying on the floor with the bed in the high position. He stated she was yelling out in pain and was bleeding from some skin tears. NA #2 stated he helped Nurse #1, NA #1 and NA #3 transfer Resident #20 back to bed and then left the room. An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was called to	F 684	dietary, therapy, and department heads. The in-services included education on resident safety (as indicated in the care plan). After 10/19/18, no facility nursing staff, nursing agency staff, or contracted therapy staff will be allowed to work until the in-services are completed. The in-service will be added to new staff orientation, including agency and contracted staff. On 10/19/18, the DON, QI nurse and SF nurse began five day per week reviews of the nursing 24-hour report sheets and progress notes looking for any new orders, incident/accidents, and/or new safety measures added, to help ensure the nursing staff, agency staff, and contracted therapy staff are following residents' care plans. On 10/22/18, the administrator, department heads, and corporate facility consultants began a process of root cause analysis using "5-Whys", during the interdisciplinary team (IDT) meeting to help ensure the residents' care plans are appropriate, updated, and are being followed by the facility staff, agency staff, and contracted therapy staff. How the facility plans to monitor its performance to make sure solutions are sustained Beginning 10/20/18, the DON will present the Insulin Audit Tool results to the interdisciplinary team (IDT) weekly for review. This review will include ensuring insulin was administered as ordered and	

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F 684	Continued From page 90 Resident #20's room by a code green and when she went in the room Resident #20 was lying on her left side with her head on the ground. She stated she didn't remember what position the bed was in. Nurse #1 stated Resident #20 was yelling out in pain while she assessed her but she had good range of motion of all extremities and multiple skin tears. Nurse #1 stated Resident #20's Responsible Party (RP) came in during the assessment and felt like the resident had broken her right shoulder/arm and wanted her sent out to the hospital. She stated she told the RP they could have an x-ray done at the facility and it would be quicker than going to the hospital and he was good with doing it that way. Nurse #1 stated she didn't remember calling the on-call provider and thought the on-coming nurse had called them but after reviewing her nurse's notes she stated, "I guess I probably called the physician and got the order for the x-ray of her shoulder." She stated she would not have told the physician Resident #20 was on Coumadin after the unwitnessed fall because she wouldn't have sent Resident #20 out, she would have started neuro checks and monitored her condition. Nurse #1 stated she did not start neuro checks but reported off to the on-coming nurse about the fall. She stated she did have NA #1 obtain vital signs. Review of the Incident note dated 09/22/18 6:44 PM revealed Resident #20 had multiple skin tears and they were cleaned and treated. The right shoulder was swollen and Responsible Party (RP) felt it was broken and wanted the resident to go to the emergency room. The note revealed Nurse #1 didn't feel her arm/shoulder was broken because she had range of motion and was using it, not in pain while moving. The Physician was contacted. An order for an x-ray was called into	F 684	insulin is available for administration. Presentation of the insulin audit tool to the IDT will serve as a second verification. Beginning 10/22/18, the DON will present the Insulin Referral Audit tool results weekly to the daily IDT for review. This review will ensure potential admissions with a need for insulin have the medication available upon admission. Presentation of the tool to the IDT will serve as a second verification to ensure resident well-being is being maintained as it relates to insulin administration. The daily IDT's role in this Resident Well-Being plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations.	

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the technician and was done at 6:00 PM in the facility.

Review of the physician order's dated 09/22/18 at 4:00 PM an order was written for Resident #20 by Nurse #1 and signed by the Physician for an x-ray of right shoulder to rule out injury from a fall.

Review of the x-ray right shoulder results dated 09/22/18 revealed there was no evidence of an acute fracture or dislocation.

Review of the nurse's notes revealed the following:

09/22/18 6:48 PM Neurological Observations - Vital Signs - 4:30 PM 143/84 Blood Pressure (B/P), 139 Pulse (P), 20 Respirations (R), 97% Oxygen saturation (O2). 5:00 PM - B/P-138/72, P-100, R-20, Temperature (temp), 98.7 96% (O2), 5:30 PM - 140/84 B/P, 98 P, 18 R, 96% O2, 6:00 PM - 150/80 B/P, 88 P, 20 R, 98/4 Temp, 94% O2, 6:30 PM - 142/86 B/P, 88 P, 20 R, 97.8 Temp, 95% O2. Level of Consciousness - 4:30 PM alert/conscious (a/c), 5:00 PM -a/c, 5:30 PM -a/c, 6:00 PM a/c, 6:30 PM -a/c. Pupil Check - 4:30 PM Pupils Equal Responsive Light (PERL), 5:00 PM -PERL, 5:30 PM - PERL, 6:00 PM -PERL, 6:30 PM -PERL. Hand Grasp - 4:30 PM =, 5:00 PM =, 5:30 PM =, 6:00 PM =, 6:30 =.

Further interview with Nurse #1 on 10/11/18 at 1:39 PM revealed she was Resident #20's nurse on 09/23/18 on the 7:00 AM to 7:00 PM shift and the resident was alert, and talking during the morning of 09/23/18. Nurse #1 stated the NA yelled for her and when she got to the room and assessed Resident #20 she had stopped breathing. She stated she checked her code

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status and she was a DNR so she didn't initiate CPR.

Two attempts were unsuccessful to interview Nurse #2 via phone on 10/11/18 at 2:00 PM and 10/12/18 at 8:40 AM.

An interview conducted on 10/11/18 at 3:57 PM with the facility Physician revealed he did not recall being called about Resident #20's fall on 09/22/18. He stated if he had been called about a resident having an unwitnessed fall was on Coumadin he would have expected her to be sent out to the hospital for evaluation and a Computed tomography, a scan to see inside the body, to rule out a bleed.

An interview conducted on 10/11/18 at 3:04 PM with the Director of Nursing revealed it was her expectation for nurse's to report to the physician that a resident's fall was unwitnessed or witnessed and what medications they were on. She further stated she expected neuro checks to be completed per facility protocol.

Review of the nurse's note dated 09/23/18 at 12:45 PM written by Nurse #1 revealed Resident #20's RP had been at her bedside since after breakfast. The NA went in to get Resident #20's vital signs and called Nurse #1 to the room. The NA stated when she put the blood pressure cuff on the resident she looked like she stopped breathing. The note revealed Nurse #1 told the RP she would send Resident #20 to the emergency room for evaluation but she stopped breathing. Resident #20 was a Do Not Resuscitate (DNR) and Cardio Pulmonary Resuscitation (CPR) was not initiated.

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Review of the Death Certificate dated 09/23/18 and signed by the Medical Examiner revealed the cause of death for Resident #20 was from complications of a hip fracture.

An interview conducted on 10/12/18 at 12:09 PM with the Medical Examiner (ME) revealed he was contacted by the funeral home due to the fact Resident #20 had a fall which was considered an accident before her death which meant the Medical Examiner had to be called. The ME stated the facility Physician had put the cause of death on the death certificate for complications of a hip fracture. The ME stated he reviewed the hospital and nursing home records for Resident #20 but was unaware she had an unwitnessed fall on 09/22/18. He stated had he known about the unwitnessed fall and the fact that she was on a blood thinner he may have looked at the case differently but it was acceptable to leave the cause of death complications from a hip fracture because that was the reason she was in the facility to begin with.

On 10/11/18 at 3:49 PM the Director of Nursing and the Corporate Consultant were notified of Immediate Jeopardy.

On 10/12/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/22/18 at approximately 3:50 pm, Resident #20 was on the floor next to the resident's bed. Resident #20 was on her side, head was on the

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floor, and demonstrated signs of pain. The nursing assistant called a code to announce the resident's fall in the resident's room.
On 9/22/18 at approximately 3:55 pm, Nurse #1 directed the nursing assistant to take vital signs. Resident #20's vital signs post fall were blood pressure 143/86, pulse 88, respirations 20, tympanic temperature 97.8 F, and oxygen saturation 95%.
On 9/22/18, Nurse #1 and three nursing assistants assisted Resident #20 to the bed.
On 9/22/18 at approximately 4:00 pm, the treatment nurse noted, cleaned, and dressed five (5) skin tears on Resident #20: right upper arm, right forearm, right knee/leg, right lower leg, left foot second toe. After completing the skin tear treatments, the treatment nurse completed five (5) individual flow sheets of non-ulcer skin conditions in the electronic health record under the assessment tab.
On 9/22/18 at approximately 4:00 pm, Nurse #1 noted Resident #20's right shoulder was swollen. The nurse notified the physician and the physician gave an order for an x-ray of the right shoulder. Nurse #1 did not notify the physician that the resident had a fall and Nurse #1 did not notify the physician that Resident #20 was taking Coumadin.
On 9/22/18 at approximately 4:30 pm the Nurse #1 initiated neurological checks on Resident #20.
On 9/22/18, the Nurse #1 completed five (5) neurological checks on Resident #20: 4:30 pm, 5:00 pm, 5:30 pm, 6:00 pm, and 6:30pm. Nurse #1 documented the neurological checks in Resident #20's electronic health record under nurse progress notes type: neurological observations. Nurse #1 reported off at approximately 7:00 pm to the oncoming shift nurse that x-ray was pending. The oncoming

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7:00 pm - 7:00 am Nurse #2 did not document any neurological checks.
On 9/23/18 at approximately 1:48 am, Nurse #2 documented a skilled post-acute note stating neurological: alert and oriented, cardiac: regular rate and rhythm, tachycardic at times, peripheral pulse present, respiratory rate clear, several wounds with dressings intact, clean, and dry.
On 9/23/18 at approximately 12:45 pm, Nurse #1 completed a discharge summary in Resident #20's electronic health record. The summary included: the assigned nursing assistant was unable to attain vital signs, the Nurse #1 was unable to attain vital signs. The Nurse #1 contacted 911. Resident #20's husband was at bedside. Resident #20 was a Do Not Resuscitate (DNR). Resident #20 was pronounced dead at approximately 12:45 pm.
On 10/11/18, the DON re-educated Nurse #1 regarding resident incident/accidents, post-fall assessments, neurological checks for all unobserved falls, documentation, shift change report, and reporting all relevant information to the physician, nurse practitioner, and DON.
On 10/11/18, the DON re-educated Nurse #2 regarding resident incident/accidents, post-fall assessments, neurological checks for all unobserved falls, documentation, shift change report, and reporting all relevant information to the physician, nurse practitioner, and DON.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/11/18, the quality improvement (QI) nurse audited 100% of resident current medication administration records (MARs) to identify all residents with current orders to receive

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Coumadin. The audit identified one (1) resident with Coumadin listed on the MAR.
On 10/11/18, the director of nursing (DON) performed an audit on 100% of residents receiving Coumadin. The audit was to identify any Coumadin resident having a fall within the past 60 days. The audit identified zero/no resident currently taking Coumadin who had a fall within the past 60 days.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On 10/11/18, the QI nurse and staff facilitator initiated a re-education for all RNs, LPNs, MAs, NAs, and contracted therapy personnel. The re-education covered: In the event of any/all falls, especially for those residents receiving medication that has blood thinning properties, the physician must be called right away. Nurses, including Nurse #1 and Nurse #2, are being instructed to use the PCC E-Interact form to ensure the nurse provides the physician with all relevant information for all falls. Nurses will document relevant information on the 24 hour report sheets and report relevant information to the on-coming shift nurse regarding all falls. Nurses must follow the facility's policy on PT/INRs when resident is on Coumadin. Nurses are being instructed to start neuro-checks and follow the posted neuro-check guidelines which details the frequency of performing the neuro-check; only licensed registered nurses and licensed practical nurses will perform the neuro-checks, NAs may take the vital signs. Repeat PT/INR after three days or as ordered by the physician/nurse practitioner. If the resident has to be sent out for evaluation and treatment

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due to an injury post-fall and the resident returns to the facility the neurological checks must be re-started at the appropriate time. The DON must be notified within two hours of all falls with injuries to ensure proper interventions are in place. The re-education was completed on 10/11/18 with all staff working; no RN, LPN, MA, NA, or contracted therapy personnel will be allowed to work, including Nurse #1 and Nurse #2, until the re-education is completed. The re-education is added to the new staff orientation for all RNs, LPNs, MAs, NAs, and contracted therapy personnel.

On 10/11/18, the QI nurse initiated a re-education for all RNs and LPNs. This re-education instructs the RNs and LPNs, including Nurse #1 and Nurse #2, to enter all neurological checks into the electronic medical record (PCC) under neurological observation. By having neurological observations documented in the PCC system, the documents are available for review by the physician, nurse practitioner, and clinical teams. The in-service was completed on 10/11/18 with all staff working; no RN or LPN will be allowed to work until the re-education is completed, including Nurse #1 and Nurse #2. The re-education is added to the new staff orientation for all RNs and LPNs.

On 10/11/18, the DON initiated in the morning inter-disciplinary team (IDT) meeting a review of all falls, to include residents on medication with blood-thinning properties. The review included verifying that an assessment was completed immediately post-fall, that the physician/nurse practitioner was notified of all falls with all relevant information provided. The resident representative was notified, if the resident is on medication with blood-thinning properties, if the resident required outside treatment, and if the DON was notified of

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F 684	Continued From page 98 the fall. 4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed) Beginning 10/11/18, the DON and/or QI nurse will review the 24 hour report sheets for all falls. Beginning 10/11/18, the DON, QI nurse, and/or staff facilitator will review the 24 hour PCC progress notes. Beginning 10/11/18, the 24 hour report sheet review findings will be reconciled with the 24 hour PCC progress note review findings to ensure all falls have documented assessments and reports to physician/nurse practitioner which include current medications with blood-thinning properties including Coumadin. These reviews and reconciliations will be completed five times each week for a period of six months. On 10/11/18, the DON and corporate clinical director notified the daily quality assurance and performance improvement (QAPI) team. The daily QAPI team's role in this plan of correction includes implementation and monitoring, ensuring the interventions are effective. The QAPI team also making recommendations for revisions as needed. The daily QAPI review findings will be brought to the next quarterly QAPI meeting for additional review and recommendations. Beginning 10/11/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley alleges credible allegation of IJ removal as of 10/11/18.	F 684		

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F 684	Continued From page 99 On 10/12/18 facility staff were interviewed and demonstrated they had been trained on the topics of using the PCC E-Interact forms to ensure nurses provided the physician with all relevant information after falls, when and how to perform neuro checks, DON notification, reporting of falls to on-coming nurse, and documenting on the 24 hour report sheets. Immediate jeopardy was removed effective 10/11/18. 2. Resident #2 was admitted to the facility on 9/11/18 with diagnoses which included: diabetes, heart disease, chronic kidney disease, and peripheral vascular disease. Review of the Medication Administration Record (MAR) for September 2018 for Resident #2 revealed on 09/11/18 Resident #2 was given 6 units of scheduled regular insulin at 12:00 PM and an additional 2 units of sliding scale insulin (SSI) for coverage of capillary blood glucose (CBG) reading of 236. Review of the September 2018 MAR further revealed Resident #2 did not receive his physician ordered insulin's of 6 units on 09/11/18 at 5:00 PM and 10 units at 9:00 PM and his sliding scale insulin coverage at 4:30 PM for a CBG of 206 that required 2 units of coverage and 8:30 PM for a CBG of 240 that required 2 units of coverage. A record review of the September 2018 MAR further revealed Resident #2 received the physician ordered 6 units of regular insulin on 09/12/18 at 8:00 AM. Resident #2 also received 6 units of SSI regular insulin on 09/12/18 at 7:30	F 684		

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AM to cover a CBG of "HI".

Review of the Blood Glucose Monitoring Sheet for 09/11/18 for Resident #2 revealed the following readings:

09/11/18 1:00 PM CBG 236
09/11/18 4:12 PM CBG 206
09/11/18 8:50 PM CBG 240

Per physician order and based on CBG reading of 206, Resident #2 should have received 2 units regular insulin on 09/11/18 at 4:30 PM.

Per physician order and based on CBG reading of 240, Resident #2 should have received 2 units regular insulin on 09/11/18 at 8:30 PM.

An interview with Nurse #3 on 10/09/18 at 1:00 PM revealed she gave Resident #2 12 units of regular insulin on 09/12/18 at 7:30 AM. This included the 6 units of regular scheduled insulin and 6 units of regular insulin for SSI coverage of CBG reading "HI". Nurse #3 further revealed the recheck of Resident #2's CBG at 9:30 AM still read "HI". Nurse #3 notified the NP, who was at the facility and she examined the resident and ordered him transferred to the hospital for possible DKA. Nurse #3 further revealed she did not recheck the glucometer when it read HI and she did not try another glucometer to verify test results.

An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his physician ordered insulin's on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. She further stated she did not give Resident #2 his Detemir insulin scheduled for 09/11/18 at

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9:00 PM. She stated she did not look for the insulin and just did not give it.

An interview with Nurse #3 on 10/10/18 at 9:30 AM revealed she obtained the regular insulin administered to Resident #2 on 09/11/18 and 09/12/18 from house stock in the emergency box.

Review of the nurse notes dated 09/12/18 at 2:05 PM revealed the CBG taken at 7:30 AM read "HI". The nurse gave Resident #2 12 units of regular insulin per physician admission orders. The CBG was rechecked at 9:30 AM which read "HI". The note further revealed Resident #2 was vomiting and not feeling well and was seen by the Nurse Practitioner (NP) who wrote an order for transfer Resident #2 to the emergency department for evaluation of possible DKA.

Review of the Nurse Practitioner (NP) progress note dated 9/12/18 indicated Resident #2 was seen on 09/12/18 after a CBG reading was 'HI'. The progress note indicated Resident #2 had also developed nausea and vomiting and he was clammy and anxious. An order was given by the NP to transfer the resident to the emergency department for possible DKA.

An interview with the NP on 10/10/18 at 10:00 AM revealed she was unaware Resident #2 had not received his insulin's the evening before he was sent to the hospital. Further interview with the NP revealed her expectation was for the facility nurse to contact the on-call physician if the insulin was not available.

An interview with Nurse #4 on 10/10/18 at 10:45 AM revealed she did not remember if she had reported to the 3rd shift nurse that Resident #2

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had not received his insulin. She stated she did not contact the on-call physician to notify them of the unavailability of insulin. Nurse #4 further stated she did not call the pharmacy to obtain the insulin or look for the insulin in the emergency box which contains emergency medications.

During an interview with Director of Nursing on 10/09/18 at 4:05 PM she stated she expected the facility staff to contact the physician for all missing medications. She further stated she expected staff to check for the ordered medications in the emergency box and to contact pharmacy for missing medications.

Review of the hospital records revealed Resident #2 was admitted to the hospital intensive care unit for DKA on 09/12/18. Blood sugar on admission to the hospital was 485. Resident #2 required an insulin drip which he was weaned from the morning of 09/13/18. He was discharged on 09/14/18.

On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone.

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 9/11/18 at approximately 11:30am, Resident #2 was admitted to Macon Valley Nursing and Rehabilitation center following a hospitalization for diagnosis including uncontrolled diabetes type 1.

On 9/11/18 at 11:30 am, Nurse #3 checked Resident #2's blood glucose; Resident #2 had a

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blood glucose reading of 236.

On 9/11/18 at 11:30 am, Nurse #3 administered to Resident #2 two units of Regular insulin subcutaneously, as ordered by the physician, for a blood glucose level of 236.

On 9/11/18 at 12 noon, Nurse #3 administered to Resident #2 six units of Regular insulin subcutaneously, as ordered by the physician.

On 9/11/18 at 4:12 pm, Nurse #4 checked Resident #2's blood glucose; Resident #2 had a blood glucose reading of 206.

On 9/11/18, the medication administration record (MAR) documentation did not show that Resident #2 received 2 units of Regular insulin for blood glucose level of 206, as ordered by physician.

On 9/11/18 5:00 pm, the MAR documentation did not show that Resident #2 received a scheduled dose of 6 units of Regular insulin, as ordered by physician.

On 9/11/18 at 8:50 pm, Nurse #4 checked Resident #2's blood glucose; Resident #2 had a blood glucose reading of 240.

On 9/11/18 at 8:50 pm, the MAR documentation did not show that Resident #2 received two units of Regular insulin for a blood glucose reading of 240, as ordered by physician.

On 9/11/18 at 9:00 pm, the MAR documentation did not show that Resident #2 received 10 units of Levemir, as ordered by physician.

On 9/12/18 at 7:30 am, Nurse #3 check Resident

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#2's blood glucose; Resident #2 had a blood glucose result of "HI".

On 9/12/18 at 7:30 am, Nurse #3 administered six units of Regular insulin subcutaneously to Resident #2 ordered by the physician.

On 9/12/18 at 8:00 am, Nurse #3 administered six units of Regular insulin subcutaneously to Resident #2, as ordered by the physician.

On 9/12/18 at 9:30 am, Nurse #3 rechecked Resident #2's blood glucose with a result of "HI".

On 9/12/18 approximately 9:30 am, Nurse #3 ensured Resident #2's well-being by: contacting the nurse practitioner of the blood glucose reading remaining "HI", administration of 6 units of Regular insulin for the initial "HI" reading, and Nurse #3 administering the scheduled 6 units of Regular insulin as scheduled by the physician's orders.

On 9/12/18, the nurse practitioner gave a verbal order to Nurse #3 for Resident # 2 to be sent to emergency room.

On 9/12/18, Resident # 2 was transferred to the hospital emergency room by emergency medical services for evaluation of elevated blood glucose.

The facility determined the root cause of the deficient practice that threatened Resident #2's well-being was the nurse's failure to follow established policy in obtaining medications when the medication is not available on the medication cart.

On 10/19/18, the DON, quality improvement (QI)

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nurse, and staff facilitator (SF) initiated the in-service titled "Promoting a Resident's Well-Being". The in-service included the importance of following physicians' orders, keeping the physician informed if unable to administer physician orders, attending to resident needs, and treating residents with dignity and respect was reviewed with all staff, including agency and contracted staff. After 10/19/18, no staff, agency, or contracted staff will be allowed to work until the in-service is completed. Nurse # 4 was educated on 10/22/18. The in-service will be added to new staff orientation, including agency and contracted staff.

Beginning 10/19/18 to correct the deficient practice, all licensed nurses, including agency staff, will be in-serviced on administering medication. Insulin must be administered per physician orders, including obtaining medications when the medication is not available on the medication cart or in the facility. After 10/19/18, no staff, agency, or contracted staff will be allowed to work until the in-service is completed. Nurse # 4 was educated on 10/22/18. The in-service with be added to new staff orientation, including agency and contracted staff.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10/19/18, the DON and unit manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders.

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On 10/22/18 the unit manager contacted the physician regarding undocumented doses of insulin. The physician gave no new orders. Multiple nurses failed to either administer insulin as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facility at multiple times during the day. The medication errors occurred due to multiple nurses' failure to follow the medication administration policy.

On 10/19/18, the DON and Unit Manager audited to ensure all residents on insulin have the insulin available in the facility. All Residents had Insulin available to match order.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing 100% of residents on insulin once daily 5 times weekly x 12 weeks to ensure insulin is available for administration as ordered. This audit will be documented on the insulin audit tool.

On 10/20/18, the DON, QI nurse, SF, administrator, and/or licensed nurse began auditing audit 100% of residents on insulin. The auditing will be completed once daily 5 times weekly x 12 weeks to ensure insulin was administered as ordered. This audit will be documented on the insulin audit tool.

On 10/20/18, the DON, QI nurse, SF, and/or administrator began reviewing all referrals to ensure if a potential resident would be on insulin and the medication is available prior to resident

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admission. This audit will be documented on the insulin referral audit tool. This audit will be completed on each referral for 12 weeks.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning 10/20/18, the DON will present the Insulin Audit Tool results to the interdisciplinary team (IDT) weekly for review. This review will include ensuring insulin was administered as ordered and insulin is available for administration. Presentation of the insulin audit tool to the IDT will serve as a second verification.

Beginning 10/22/18, the social worker (SW) will present the Insulin Referral Audit tool results weekly to the daily IDT for review. This review will ensure potential admissions with a need for insulin have the medication available upon admission. Presentation of the tool to the IDT will serve as a second verification to ensure resident well-being is being maintained as it relates to insulin administration.

The daily IDT's role in this Resident Well-Being plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations. On 10/22/18, the administrator notified the QAPI committee of the significant medication error IJ and the facility's plan of correction, including the QAPI

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F 684	Continued From page 108 committee's role in the plan of correction. Beginning 10/19/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley alleges compliance of removal of IJ as of 10/22/18. On 10/23/18 facility staff were interviewed and demonstrated they had been trained on the topics of medication administration, and how to call the pharmacy for medications, and to notify the physician if medications weren't available. Immediate jeopardy was removed effective 10/22/18.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to place a bed in the low position which resulted in a fall from the bed in high position for Resident #20 causing the need for a shoulder x-ray and skin tears (Resident #20). The findings included:	F 689	F 689 How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/11/18 - 10/19/18, the director of	12/5/18

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F 689	Continued From page 109 Resident #20 was admitted to the facility on 09/17/18 with diagnoses included hip fracture repair, high blood pressure, atrial fibrillation, peripheral vascular disease, and chronic obstructive pulmonary disease. Review of the admission nursing assessment dated 09/17/18 revealed Resident #20 was alert to person, place and time. Review of the care plan dated 09/18/18 revealed Resident #20 was at risk for falls/actual falls, injury, multiple risk factors related to deconditioning, incontinence, impaired balance and impaired mobility. The goal was for Resident #20 to be free of falls, and not sustain serious injury through the next review. The interventions included having the resident's bed in the lowest position. Review of the Incident note written by Nurse #1 and dated 09/22/18 6:44 PM revealed Resident #20 had multiple skin tears and they were cleaned and treated. The right shoulder was swollen and Responsible Party (RP) felt it was broken and wanted the resident to go to the emergency room. The note revealed Nurse #1 didn't feel her arm/shoulder was broken because she had range of motion and was using it, not in pain while moving. The Physician was contacted. An order for an x-ray was called into the technician and was done at 6:00 PM in the facility. Review of the physician order's dated 09/22/18 at 4:00 PM an order was written for Resident #20 by Nurse #1 and signed by the Physician for an x-ray of right shoulder to rule out injury from a fall. Review of the x-ray right shoulder results dated	F 689	nursing (DON) and quality improvement (QI) nurse audited Resident #20's nursing progress notes and interviewed floor nurses and nursing assistants (NAs) regarding Resident #20's accident. Resident #20 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/11/18 – 10/19/18, the DON and QI nurse audited 100% of nurse progress notes for all residents looking for any documented incidents/accidents. The audit revealed no other incidents accidents that had not been previously identified and corrective action taken. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur: On 10/11/18, the QI nurse initiated a 100% in-service with all registered nurses (RNs), licensed practical nurses (LPNs), nursing assistants (NAs), geriatric care assistants (GCAs) and agency staff. The in-service included the nurse must notify the physician immediately of residents with unwitnessed falls that are on medications with blood thinning properties. Neurological checks must be started and the nurse must follow the facility's policy on neurological checks. If	

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F 689	Continued From page 110 09/22/18 revealed there was no evidence of an acute fracture or dislocation. An interview conducted on 10/10/18 at 11:07 AM with Nurse Aide (NA) #1 revealed he had just started his shift and was doing his first set of rounds when he heard Resident #20 screaming around 3:45 PM. He stated he went to her room and she was lying on her right side with her right arm underneath her and her head lying on the floor facing the bed. NA #1 stated Resident #20 was bleeding from skin tears to both sides of her body. He stated he knew what fall precautions were in place for residents from the Resident Care Guide and Resident #20's care indicated her bed was to be in the lowest position and it was in the high position when he found Resident #20 on the floor. An interview conducted on 10/10/18 at 12:05 PM with NA #3 revealed she helped NA #2 transfer Resident #20 from the chair to the bed on 09/22/18 close to shift change around 2:45 PM and then went back to her hall. She stated she heard the code green around 4:00 PM and went to Resident #20's room. She stated Resident #20 was lying on the floor with her head on the floor facing her bed that was in the high position. An interview conducted on 10/11/18 at 10:30 AM with NA #2 revealed he had transferred Resident #20 from the chair to the bed just before shift change on 09/22/18 and he was at the nurse's desk and heard the code green called. He stated he went to Resident #20's room and she was lying on the floor on her right side with her right arm twisted underneath her and her head was lying on the floor with the bed in the high position. NA #2 further stated Resident #20's should have	F 689	the resident is sent to the ER for evaluation and treatment due to an injury, the neurological checks must be restarted when the resident returns to the facility at the appropriate time. The DON must be notified of all falls with injuries, especially residents on blood thinners, within 2 hours of the incident to ensure the intervention is appropriate. On 10/11/18 – 10/15/18, the corporate nurse consultants mentored the administrator, DON, QI nurse and SF on where to find and access corporate policies, procedures, and action checklists. The corporate nurse consultants also assisted with drafting in-services to include falls investigations and neurological check documentation. On 10/19/18, the DON and staff facilitator (SF) initiated multiple in-services for 100% of appropriate staff to include registered nurses (RNs), licensed practical nurses (LPNs), NAs, geriatric care assistants, agency staff, housekeeping, laundry, dietary, therapy, and department heads. The in-services included education on resident safety to prevent a fall and neurological checks after a fall. After 10/19/18, no facility nursing staff, nursing agency staff, or contracted therapy staff will be allowed to work until the in-services are completed. On 10/19/18, the in-service was added to new staff orientation, including agency and contracted staff. On 10/19/18, the DON, QI nurse and SF	

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F 689	Continued From page 111 been in the low position per the Resident Care Guide and it was in the high position when he entered Resident #20's room after her fall. An interview conducted on 10/11/18 at 1:39 PM with Nurse #1 revealed she was called to Resident #20's room by a code green and when she went in the room Resident #20 was lying on her left side with her head on the ground. She stated she didn't remember what position the bed was in. Nurse #1 stated Resident #20 was yelling out in pain while she assessed her but she had good range of motion of all extremities and multiple skin tears. Nurse #1 stated Resident #20's Responsible Party (RP) came in during the assessment and felt like the resident had broken her right shoulder/arm and wanted her sent out to the hospital. She stated she told the RP they could have an x-ray done at the facility and it would be quicker than going to the hospital and he was good with doing it that way. Nurse #1 stated she didn't remember calling the on-call provider and thought the on-coming nurse had called them but after reviewing her nurse's notes she stated, "I guess I probably called the physician and got the order for the x-ray of her shoulder." Review of the Incident note written by Nurse #1 and dated 09/22/18 6:44 PM revealed Resident #20 had multiple skin tears and they were cleaned and treated. The right shoulder was swollen and Responsible Party (RP) felt it was broken and wanted the resident to go to the emergency room. The note revealed Nurse #1 didn't feel her arm/shoulder was broken because she had range of motion and was using it, not in pain while moving. The Physician was contacted. An order for an x-ray was called into the	F 689	nurse began five day per week reviews of the nursing 24-hour report sheets looking for any new medication orders, incident/accidents, notification of changes to the physician/nurse practitioner (NP) in the progress notes, new safety measures added, and neurological checks after a fall. On 10/22/18, the administrator, department heads, and corporate facility consultants began a process of root cause analysis using “5-Whys”, during the interdisciplinary team (IDT) meeting. A root cause analysis was completed for why the facility failed place a bed in the low position which resulted in a fall from the bed in high position for Resident #20 causing the need for a shoulder x-ray and skin tears. The root cause determined there was a lack of communication between the nursing staff and within the nursing department regarding Resident #20’s safety needs; beds should be left in the appropriate height position for the resident. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when correction action will be competed). On 10/19/18, the administrator initiated multiple audit tools which will be completed by the department heads (DON, QI nurse, SF, social worker, dietary manager, activities, activity director, and	

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F 689	Continued From page 112 technician and was done at 6:00 PM in the facility. Review of the physician order's dated 09/22/18 at 4:00 PM an order was written for Resident #20 by Nurse #1 and signed by the Physician for an x-ray of right shoulder to rule out injury from a fall. Review of the x-ray right shoulder results dated 09/22/18 revealed there was no evidence of an acute fracture or dislocation. Further interview with Nurse #1 on 10/11/18 at 1:39 PM revealed she was Resident #20's nurse on 09/23/18 on the 7:00 AM to 7:00 PM shift and she had no complaints of shoulder pain that day. An interview conducted on 10/11/18 at 3:04 PM with the Director of Nursing revealed it was her expectation for staff to follow fall preventions put in place for residents. She stated Resident #20's bed should have been in the low position when she was in bed unless staff were providing care and then after providing care the bed should be put back in the low position to prevent injuries from a fall.	F 689	weekend manager-on-duty). The audits will include supervision observations utilizing the Administrative Rounds tool to ensure residents are free of accident hazards, have adequate supervision and safe devices to use. On 10/19/18, the administrator, DON, QI nurse, SF, vice president of operations and/or corporate consultant began reviews of the audit tool results weekly for six months to validate the facility has provided each resident with supervision and devices to prevent incidents and accidents. The administrator, DON, vice president, and/or corporate consultant will initial the bottom right corner of the audit tools with the date as validation of review. On-going mentoring with the administrator and administrative team will continue to be provided by the vice president of operations and/or corporate consultant team at a minimum of at least monthly. On 10/20/18 and 10/22/18, the vice president of operations contacted the Quality Improvement Organization (QIO) and requested mentoring assistance monitoring recommendations. On-going mentoring will also be provided to the administrator and administrative team by the QIO beginning 10/26/18 during a facility visit. On 10/26/18, the administrator began working with the QIO to improve effective leadership and management and seek guidance on how changes leadership can make to implement a safe, hazard-free environment for the residents.	

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F 689	Continued From page 113	F 689	Beginning 10/19/18, the administrator, DON, and QI nurse will present the in-service/mentoring comments, supervision observations, and audit trends to the IDT and monthly QI committee for six months. The IDT and QI committee will review incident investigation files to ensure there is adequate supervision, safety measures are in place, beds are in proper position, devices are safe, and neurological check documentation is completed. The administrator and/or DON will present the daily IDT and monthly QI committee recommendations to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance. The QAPI committee will continue consulting with the QIO until substantial compliance is achieved.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		12/5/18

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F 690	Continued From page 114 resident's clinical condition demonstrates that catheterization was necessary; (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 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure a resident's urinary catheter bag was not in contact with the floor (Resident #14). The findings included: Resident #14 was admitted to the facility on 06/16/15 and most recently on 09/21/18 with diagnoses which included: dementia without behaviors, hypertension, coronary artery disease, urinary retention, and benign prostatic hyperplasia with lower urinary tract symptoms. The admission Minimum Data Set (MDS) dated 09/28/18 revealed that Resident #14 was moderately cognitively impaired. He was coded	F 690	F690 How corrective action will be accomplished for those residents found to have been affected by the deficient practice On 10/09/18, Nurse #3 had Resident #15's urinary catheter bag changed and re-hung on the wheelchair so there was a privacy cover and the catheter bag was not in contact with the floor. On 10/09/18, the director of nursing (DON) re-educated NA #5 regarding maintaining dignity of residents in relation to privacy covers on urinary catheter bags and the urinary catheter bags not being in contact with the floor.	

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F 690	Continued From page 115 as requiring extensive assistance with most activities of daily living skills (ADL) including bathing. The MDS further revealed Resident #14 had an indwelling catheter during the reference period. An observation of Resident #14 on 10/09/18 at 7:45 am, revealed resident sitting in wheelchair beside bed in room with urinary catheter bag was uncovered on wheelchair just below arm rest. Interview with NA #5 on 10/09/18 at 7:55 am revealed he usually placed urinary bags under the wheelchair. An observation made on 10/09/18 at 8:57 am of Resident #14 in the resident's room revealed his urinary catheter bag was hanging under his wheelchair and dragging the floor. An observation made on 10/09/18 at 11:10 am of Resident #14 in the facility front hallway revealed his urinary bag was hanging under his wheelchair and dragging the floor. An observation made on 10/09/18 at 12:03 pm of Resident #14 exiting therapy room revealed his urinary bag was hanging under his wheelchair and dragging the floor. An observation made on 10/09/18 at 12:42pm of Resident #14 in the facility dining room revealed his urinary bag was hanging under his wheelchair and dragging the floor. An interview and observation conducted on 10/09/18 at 4:45 pm revealed Resident #14 was outside on the front porch of the facility with his urinary catheter bag lying on the ground. Nurse	F 690	How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/09/18, the quality improvement (QI) nurse and DON audited urinary catheter bags to ensure they were not in contact with the floor. The audit revealed no other issues related to urinary catheter bags in contact with the floor. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 11/6/18, the staff facilitator (SF) initiated a 100% re-education of registered nurses (RNs), licensed practical nurses (LPNs), NAs, and all agency staff titled “Foley Catheter”. The re-education instructs staff “…all catheter bags and/or tubing must remain off the floor as an infection control prevention practice”. The in-service was completed 11/28/18 and added to the new employee orientation for all new RNs, LPNs, NAs, and all nursing agency staff. After 11/28/18, no RN, LPN, NA, or agency staff is allowed to work until the in-service is completed. Beginning 11/28/18, the DON, QI nurse, SF, unit manager, activities director, social worker, administrator, manager on duty, and corporate consultant began administrative rounds to ensure urinary catheter bags are not in contact with the floor. The results of the administrative rounds is being documented the 100% Catheter Audit sheet. The administrative	

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F 690	Continued From page 116 #3 stated with the urinary catheter bag should not be lying on the ground or dragging the ground. Nurse #3 repositioned bag so it would not drag on the ground. An interview with the Director of Nursing (DON) on 10/09/18 at 4:05 pm revealed urinary catheter bags should be positioned so they don't drag or lay on the floor.	F 690	rounds, including monitoring for urinary catheter bag touching the floor, will be completed five (5) times weekly for four (4) weeks, then once weekly times eight (8) weeks, then once monthly for one month. How the facility plans to monitor its performance to make sure that solutions are sustained Beginning 11/28/18, the QI nurse will review the results of the audits with the monthly QI committee for four (4) months to identify trends, corrective actions, and to determine the need for and/or frequency of continued monitoring to maintain compliance. The QI nurse will present trends and QI committee recommendations to the quarterly quality assurance and performance improvement (QAPI) Committee for further recommendations and oversight.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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	F 725		12/5/18

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F 725	Continued From page 117 accordance with the facility assessment required at §483.70(e). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family interviews and staff interviews, the facility failed to provide sufficient staffing and scheduling to meet the needs showering, nail and hand care, and/or keeping water accessible for 7 of 7 sampled residents reviewed for these areas. (Residents #1, #5, #10, #13, #16, #19 and #21) The findings included: This tag is crossed referred to: 1. F558: Accommodation of Needs: Based on observations, record review and family and staff interview, the facility failed to maintain fluids within the reach of 3 of 15 sampled residents. (Residents #1, #4, and #13). An interview with Nurse Aide (NA) #4 on 10/10/18 at 2:02 PM revealed that sometimes when the	F 725	F 725 – Sufficient Staffing The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency – the facility failed to provide sufficient nursing staff and scheduling to meet the needs showering, nail and hand care, and/or keeping water accessible. (Residents #1, #5, #10, #13, #16, #19 and #21). The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 10/16/18, the facility signed a contract with a staffing agency to provide sufficient nursing staffing. On 10/16/18, the facility began offering a sign on bonus for certified nursing	

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F 725	Continued From page 118 geriatric care assistants bring the residents back from a meal in the dining room, they failed to ensure the fluids are in their reach. She stated there was not enough staff to keep up with all the residents' needs. Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff. The DON stated the facility used geriatric care assistants to help with anything that was not hands on care as they were not nurse aides. She confirmed that 10/09/18 there was not enough staff scheduled. 2. F561: Choices for showers: Based on observations, resident, family and staff interviews and record reviews, the facility failed to honor the choices of 7 of 7 sampled residents to be showered or receive baths as often as they preferred. (Residents #1, #5, #10, #13, #16, #19 and #21). On 10/09/18 at 9:01 AM, Nurse Aide (NA) #4 stated she usually worked the hall alone and was unable to get all the care completed. She did quick bed baths, washing the underarms and peri-area when getting residents up but was unable to give full baths/showers. She stated that she has told Administration about the care not being completed. Interview with NA #3 on 10/10/18 at 9:54 AM revealed that there is often no time to give showers on the hall so she does her best to wash residents up but not in the shower. She further stated there have been lots of complaints about showers being missed. NA #1 stated on 10/10/18 at 10:48 AM, that when	F 725	assistants, licensed practical nurses, and registered nurses. On 10/16/18, the facility posted a hiring ad in the local newspaper to provide sufficient nursing staffing. On 11/7/18, the facility began nursing assistant (NA) classes at South Western Community College. The facility sponsored seven students. On 11/15/18, the facility signed an additional contract with a staffing agency to provide sufficient nursing staffing. By 11/19/18, the facility administrator will in-service the director of nursing (DON) on providing adequate staffing for the facility. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The DON, staff facilitator (SF), and/or quality improvement (QI) on duty will audit daily staffing for 8 weeks. This monitoring tool will be documented on the Adequate staffing Monitoring Tool. The monthly QI committee will review the results of the Adequate Staffing Monitoring tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 725	Continued From page 119 he floated between the halls, he had actually no assignment and so he spent one hour on one hall, then moved to another hall for an hour and then moved to the next hall for an hour. He stated he was to be available to assist as needed. Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed some days there was not enough staff to get the bathing completed. She stated she has received a lot of complaints from families and residents about showers not being completed. She confirmed that 10/09/18 there was not enough staff scheduled. She stated NA #1 was a floater on 10/09/18 at he was responsible for assisting with 2 person transfers and to give showers. DON the floater (NA #1) needed to be retrained. 3. F677: Activities of Daily Living Skills: Based on observations, record review, and staff interviews, the facility failed to provide care to ensure hands and fingernails were clean and oral care was completed for 1 of 7 sampled residents reviewed for activities of daily living skills. (Resident #1). On 10/09/18 at 4:46 PM, Nurse Aide (NA) #4 stated during interview that she had not done any mouth care on Resident #1 this date. She also stated she did not do hand care and did not notice dirty nails or hands. She stated there was not enough staff scheduled and working to get all the necessary care completed. Interview with the Director of Nursing (DON) on 10/10/18 at 6:33 PM revealed she expected hand and mouth care to be completed. She stated she noticed his thumb nail this morning needed attention. She further stated there were some days there was not enough staff. She confirmed	F 725	The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 725	Continued From page 120 that 10/09/18 there was not enough staff scheduled.	F 725		
F 760 SS=J	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 observations, record review, resident, staff, and Nurse Practitioner interviews, the facility failed to administer physician ordered insulin medication to keep residents free of significant medication errors in accordance with accepted professional standards and principles for 1 of 3 residents reviewed for pharmacy services (Resident #2). Immediate Jeopardy began on 09/11/18 when Nurse #4 did not administer insulin per physician's order which resulted in Resident #2 developing DKA. Immediate Jeopardy was removed on 10/22/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #2 was admitted to the facility on 9/11/18 with diagnoses which included: diabetes, heart disease, chronic kidney disease, and peripheral vascular disease.	F 760	F 760 - Significant Medication Error How corrective action will be accomplished for those residents found to have been affected by the deficient practice On the morning of 9/12/18, Resident #2 experienced at FSBS reading of “HI.” The resident received two doses of 6 units of Regular Insulin; however the resident’s FSBS reading would not drop below “HI.” Resident #2 was sent to the emergency room, where the resident was admitted with diabetic ketoacidosis, and placed on an insulin drip to lower his blood sugar. On 10/17/18, the director of nursing (DON) interviewed Nurse #4 assigned to Resident #2, for date of service 09/11/18, which revealed Nurse #4 did not give the insulin because it was unavailable. How the facility will identify other residents having the potential to be affected by the same deficient practice On 10/19/18, the DON and unit manager	12/5/18

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F 760	Continued From page 121 Record review of the Medication Administration Record (MAR) for September 2018 for Resident #2 revealed on 09/11/18 Resident #2 was given 6 units of scheduled regular insulin at 12:00 PM and an additional 2 units of sliding scale insulin (SSI) for coverage of capillary blood glucose (CBG) reading of 236. Review of the September 2018 MAR further revealed Resident #2 did not receive his physician ordered insulin's of 6 units on 09/ 11/18 at 5:00 PM and 9:00 PM and his sliding scale insulin coverage at 4:30 PM for a CBG of 206 that required 2 units of coverage and 8:30 PM for a CBG of 240 that required 2 units of coverage. Review of the Blood Glucose Monitoring Sheet for 09/11/18 for Resident #2 revealed the following readings: 09/11/18 1:00 PM CBG 236 09/11/18 4:12 PM CBG 206 09/11/18 8:50 PM CBG 240 Per physician order and based on CBG reading of 206, Resident #2 should have received 2 units regular insulin on 09/11/18 at 4:30 PM. Per physician order and based on CBG reading of 240, Resident #2 should have received 2 units regular insulin on 09/11/18 at 8:30 PM. An interview with Nurse #3 on 10/09/18 at 1:00 PM revealed she gave Resident #2 12 units of regular insulin on 09/12/18 at 7:30 AM. This included the 6 units of regular scheduled insulin and 6 units of regular insulin for SSI coverage of CBG reading "HI". Nurse #3 further revealed the	F 760	reviewed the medication availability of all facility residents receiving insulin to ensure insulin was available. This review compared each resident's current insulin orders with the medication administration record (MAR) and the insulin available in the medication carts. No concerns were identified, all residents with an order for insulin had insulin available. On 10/19/18, the DON and unit manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders. On 10/22/18 the unit manager contact the physician regarding undocumented doses of insulin. The physician gave no new orders. Multiple nurses failed to either administer insulin as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facility at multiple times during the day. The medication errors occurred due to multiple nurses' failure to follow the medication administration policy. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur On 10/19/18, the DON, QI nurse and staff facilitator (SF) began education with all licensed nurses to include agency staff on the importance of following insulin orders. This education included: 1) the physician must be notified anytime the prescribed	

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F 760	Continued From page 122 recheck of Resident #2 CBG at 9:30 AM still read "HI". Nurse #3 notified the NP, who was at the facility and she examined the resident and ordered him transferred to the hospital for possible diabetic ketoacidosis (DKA). An interview with Nurse #4 on 10/10/18 at 9:06 AM revealed she did not give Resident #2 his regular insulin on 09/11/18 at 4:30 PM and 09/11/18 at 5:00 PM or 09/11/18 at 8:30 PM. Nurse #4 further stated she did not give Resident #2 his 10 units of Detemir insulin scheduled for 09/11/18 at 9:00 PM. A follow up interview with Nurse #3 on 10/10/18 at 9:30 AM revealed she obtained the regular insulin administered to Resident #2 on 09/11/18 and 09/12/18 from house stock in the emergency box. A review of the Nurse Practitioner (NP) progress note dated 9/12/18 indicated Resident #2 was seen on 09/12/18 after a CBG reading was 'HI'. The progress note indicated Resident #2 had also developed nausea and vomiting and he was clammy and anxious. An order was given by the NP to transfer the resident to the emergency department for possible DKA. An interview with the NP on 10/10/18 at 10:00 AM revealed she was unaware Resident #2 had not received his insulin's the evening before he was sent to the hospital. Further interview with the NP revealed her expectation was for the facility nurse to contact the on-call physician if the insulin was not available. A follow up interview with Nurse #4 on 10/10/18 at 10:45 AM revealed she did not remember if she had reported to the 3rd shift nurse that Resident	F 760	insulin is not available to administer as ordered, 2) the contents of the EDK are available for use if the medication ordered for the resident is not available, 3) insulin cannot be missed, the nurse must address immediately. On 11/26/18, the education was 100% completed with all registered nurses (RNs) and licensed practical nurses (LPNs). No was allowed to work until the education was completed. How the facility plans to monitor its performance to make sure solutions are sustained Beginning 10/19/18, the DON, QI nurse, SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available, given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly for (4)four weeks, then weekly for 8 weeks, then monthly for three months. The results of the audit will be recorded on the Insulin Audit Sheet. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures. The daily IDT's role in this plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as	

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F 760	Continued From page 123 #2 had not received his insulin. She stated she did not contact the on-call physician to notify them of the unavailability of insulin. Nurse #4 indicated she did not call the pharmacy to obtain the insulin or look for the insulin in the emergency box which contains emergency medications. During an interview with Director of Nursing on 10/09/18 at 4:05 PM she stated she expected the facility staff to contact the physician for all missing medications. She further revealed she expected staff to check for the ordered medications in the emergency box and to contact pharmacy for missing medications. Review of the hospital records revealed Resident #2 was admitted to the hospital intensive care unit for DKA on 09/12/18. Blood sugar on admission to the hospital was 485. Resident #2 required an insulin drip which he was weaned from the morning of 09/13/18. He was discharged on 09/14/18. On 10/18/18 at 8:30 AM the Director of Nursing and the Administrator were notified of Immediate Jeopardy via telephone. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 was admitted to the facility on 09/11/18, with a primary diagnosis of uncontrolled diabetes mellitus with hyperglycemia. Resident #2 had insulin orders for 6 units of Regular insulin with meals, 10 units of Detemir (Levemir) at bedtime and a sliding scale of Regular insulin before meals and at bedtime.	F 760	needed. The daily IDT review findings are brought to the quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations. Beginning 10/19/18, the DON will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained.	

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F 760	Continued From page 124	F 760		

On 9/11/18 at approximately 4:12 pm, Resident #2's finger-stick blood sugar (FSBS) was 206. Nurse #4 did not administer 2 units of Regular insulin, sliding scale (SS), as ordered by the physician. Nurse #4 did not follow the system place for when medication is not available. Nurse #4 should have obtained insulin from the emergency drug kit (EDK) or contacted the physician to give the physician opportunity to alter treatment. Upon accessing the EDK, Nurse #4 failed to identify the medication.

On 9/11/18 at approximately 5 pm, Resident #2's supper meal coverage dose of Regular Insulin 6 units were not given.

On 9/11/18 at approximately 8:50 pm, Resident #2's FSBS was 240. 2 Units of SS Regular Insulin were not given.

On 9/11/18 9 pm, Resident #2's bedtime dose of Levemir 10 units were not given.

On the morning of 9/12/18, Resident #2 experienced at FSBS reading of "HI." The resident received two doses of 6 units of Regular Insulin; however the resident's FSBS reading would not drop below "HI." Resident #2 was sent to the emergency room, where the resident was admitted with Diabetic Ketoacidosis, and placed on an insulin drip to lower his blood sugar.

On 10/17/18, the director of nursing (DON) interviewed Nurse #4 assigned to Resident #2, for date of service 09/11/18, which revealed Nurse #4 did not give the insulin because it was unavailable.

2. How the facility will identify other residents

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F 760	Continued From page 125	F 760		

having the potential to be affected by the same deficient practice:

On 10/19/18, the DON and unit manager reviewed the medication availability of all facility residents receiving insulin to ensure insulin was available. This review compared each resident's current insulin orders with the medication administration record (MAR) and the insulin available in the medication carts. No concerns were identified, all residents with an order for insulin had insulin available.

On 10/19/18, the DON and unit manager reviewed all current residents on insulin to ensure no other doses were omitted in the last 30 days. The review identified 28 occurrences where the administration of insulin was not documented according to physician's orders.

On 10/22/18 the unit manager contact the physician regarding undocumented doses of insulin. The physician gave no new orders. Multiple nurses failed to either administer insulin as ordered or failed to document administration of insulin as ordered on multiple residents, throughout the facility at multiple times during the day. The medication errors occurred due to multiple nurses' failure to follow the medication administration policy.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

On 10/19/18, the DON, QI nurse and staff facilitator (SF) began education with all licensed nurses on the importance of following insulin

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F 760	Continued From page 126	F 760		

orders. This education included: 1) the physician must be notified anytime the prescribed insulin is not available to administer as ordered, 2) the contents of the EDK are available for use if the medication ordered for the resident is not available, 3) insulin cannot be missed, the nurse must address immediately.

On 10/21/18, the education was 50% completed with all registered nurses (RNs) and licensed practical nurses (LPNs). No nurse is allowed to work until the education is completed.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when corrective action will be completed)

Beginning 10/19/18, the DON, QI nurse, SF, or unit manager will audit each resident receiving insulin to ensure their insulin was available and given as ordered, and if the MD was notified if insulin was not administered as ordered. This audit will be completed five times weekly and recorded on the Insulin Audit Sheet. Any concerns identified by the auditor will have corrective action taken by the auditor immediately. The completed audits will be reviewed at the daily interdisciplinary team (IDT) meeting for additional corrective measures.

The daily IDT's role in this plan of correction includes implementation, monitoring, and ensuring the interventions are effective. The IDT also makes recommendations for revisions as needed. The daily IDT review findings will be brought to the next quarterly quality assurance and performance improvement (QAPI) meeting for additional review and recommendations. On

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F 760	Continued From page 127 10/22/18, the administrator notified the QAPI committee of the significant medication error IJ and the facility's plan of correction, including the QAPI committee's role in the plan of correction. Beginning 10/19/18, the administrator will be responsible for implementing and monitoring corrective measures to ensure solutions are sustained. Macon Valley Nursing and Rehabilitation Center alleges compliance of removal of IJ, F 760, as of 10/22/18. On 10/23/18 facility staff were interviewed and demonstrated they had been trained on the topics of medication administration, and how to call the pharmacy for medications, and to notify the physician if medications weren't available. Immediate jeopardy was removed effective 10/22/18.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		12/5/18

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F 761	Continued From page 128 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure medications in 1 of 3 medication rooms (back of 100 hall). The findings included: On 10/09/18 at 6:57 AM, the 100 hall medication room near Room 129 was observed propped open with a shelving unit. A sign on the door stated "This door must remain locked at all times". Observations of the medication room revealed it stored over the counter medications, insulin syringes and a medication refrigerator with a vial of pneumonia vaccine and a vial of tuberculin PPD (purified protein derivative) solution. This was in a hallway that was under construction, however, the hall was not blocked off from access from the upper 100 hall or the 200 hall. On 10/10/18 at 9:02 AM, The Director of Nursing stated that the hallway had been under construction for a while. The interview further revealed she expected the medication room locked at all times and it should never have been propped open or accessible to anyone.	F 761	F761 The plan of correcting the specific deficiency The position of Macon Valley Nursing and Rehabilitation center regarding the process that lead to this deficiency-failed to secure medications- was the staff failure to follow policies for medication storage due to knowledge deficit. On 10/9/28 at 6:57 AM, Hall 100 medication room was propped open with a shelving unit. On 11/8/18 the director of nurses, unit manager, quality improvement nurse (QI) and staff facilitator (SF) audited 100% of medication rooms to ensure all medications were in date and stored according to the medication storage policy. No negative findings were observed. On 11/7/18, the staff facilitator started a 100% in-service with all licensed nurses to include agency staff, on secure storage must be maintained for medications.	

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F 761	Continued From page 129	F 761	Medication rooms cannot be left open. Medication room doors must remain closed and locked at all times for all licensed nurses, and medication aides. This in-service will be complete by 11/19/18. No licensed nurses or medication aides will be allowed to work after 11/19/18 until in-service completed. This in-service will be included with orientation for all newly hired licensed nursing staff, and medication aides. The director of nursing, QI nurse, unit manager, and/or SF will audit all medication rooms five times per week for (4) four weeks, then weekly for twenty weeks to ensure the rooms remain locked at all times. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of Nursing is responsible for implementing the plan of correction.	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	F 835		12/5/18

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F 835	Continued From page 130 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff, Physician, Nurse Practitioner, and Medical Examiner interviews and medical record reviews the facility Administration failed to provide effective leadership and oversight of processes and policies and procedures to ensure that residents were provided basic nursing care and free from abuse for 3 of 3 residents reviewed for abuse, neglect, well being, notification of change, and medication administration (Resident's #2, #3, #20). Immediate Jeopardy began on 09/11/18 for Resident #2 when Nurse #4 did not notify the physician of the unavailability of the physician ordered insulin's which resulted in Resident #2 developing DKA. Immediate Jeopardy began on 09/22/18 for Resident # 20 when the facility failed to perform neurological checks per the facility's neurological guide after a fall from the bed to the floor and failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner. Immediate jeopardy began for Resident #3 on 10/1/18 when Nurse Aide (NA) #1 observed NA #8 forcibly trying to make Resident #3 sit down on the toilet and yelling at her for being soiled. Immediate Jeopardy was removed for Resident # 20 on 10/11/18 and 10/22/18 for Resident # 2 and Resident # 3 when the facility implemented a credible allegation of Immediate Jeopardy removal.	F 835	F 835 Administration Macon Valley Nursing and Rehabilitation Center was placed into Immediate Jeopardy on October 19, 2018. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/11/18, Nurse #4 failed to follow the physician□s order by not administering insulin to Resident #2 as prescribed. On 9/12/18, Resident #2□s blood glucose level continued to register as HI; the nurse practitioner gave an order to send Resident #2 to the hospital. The director of nursing (DON) failed to effectively implement training and monitoring processes to maintain Resident #2□s highest practicable physical well-being. On 9/22/18, Nurse #1 and Nurse #2 failed to initiate neurological checks and properly inform the physician of Resident #20□s change in condition after a fall. The DON failed to effectively implement training and supervision to ensure basic care was provided to attain Resident #20□s highest practicable well-being. On 10/1/18, nursing assistant (NA) #1	

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F 835	Continued From page 131 The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: 1. This tag is cross referred to F 580: Based on staff interviews, Nurse Practitioner interview, and record reviews, the facility failed to notify the physician of the missing insulin medication which caused the resident to be sent to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed for notification of change (Resident #2). The failure of the facility to notify the physician resulted in Resident #2 not receiving the medications he needed to prevent admission to the hospital for DKA. Based on record review, staff, and Physician, the facility failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner for one of three sampled residents reviewed for notification of change. The failure of the facility to communicate an unwitnessed fall from bed to the floor and blood thinner use to the physician resulted in the high likelihood of serious injury or death (Resident #20). 2. This tag is cross referred to F 600: Based on record review and staff interviews the facility failed to protect a cognitively impaired resident from being handled roughly by a staff	F 835	abused Resident #3 when NA #1 held the resident to keep the resident from leaving the bathroom during incontinent care. NA #8 failed to follow the abuse policy when NA #8 did not intervene and immediately report NA #1□s abuse of a resident. On 10/11/18 upon notification of abuse, the DON ensured Resident #3 was safe and initiated an abuse investigation. Upon completion of the investigation, the DON determined quality of life, quality of care, and resident abuse issues occurred due to staff not being properly trained lack of supervision, and staff burnout. On 10/11/18 - 10/19/18, the DON and quality improvement (QI) nurse audited Resident #20□s and Resident #2□s medication administration record (MAR) and nursing progress notes, inspected the emergency drug kit (EDK), reviewed neurological checks, and interviewed nurses. The DON identified effective systems were not in place to maintain Resident #20□s and Resident #2□s highest practicable physical, mental, and psychosocial well-being. The reviews and audits revealed communication breakdowns within the nursing department created deficiencies in facility practices related to training on policies, following physician orders, notifying physician of changes, medication errors, and providing basic nursing care which neglected Resident #20□s, and Resident #2□s well-being. 2. How the facility will identify other	

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F 835	Continued From page 132 member for 1 of 3 residents reviewed for abuse (Resident #3). Based on record review, resident, staff, and Nurse Practitioner interviews the facility failed to administer insulin per physician order's or contact physician which caused the resident to be sent out to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed with insulin dependent diabetes (Resident #2). 3. This tag is cross referred to F607: Based on record review and staff interviews the facility failed to implement their abuse policy and procedures to protect the resident, report, and investigate an allegation of staff to resident abuse for 1 of 3 residents reviewed for abuse (Resident #3). 4. This tag is cross referred to F 684: Based on record review, staff, Physician and Medical Examiner interviews, the facility failed to perform neurological checks per the facility's neurological guide after a fall from the bed to the floor and failed to communicate to the physician that the resident had an unwitnessed fall and was on a blood thinner. This affected one of three sampled residents reviewed for assessment following an acute episode. The failure of the facility to assess Resident #20's neurological status per the facility's protocol and communicate an unwitnessed fall from the bed to the floor and blood thinner use to the physician resulted in the high likelihood of serious injury or death (Resident #20).	F 835	residents having the potential to be affected by the same deficient practice: On 10/19/18, the DON and staff facilitator (SF) initiated multiple in-services for 100% of appropriate staff to include the Administrator, RNs, LPNs, nursing assistants, geriatric care assistants, agency staff, housekeeping, laundry, dietary, therapy, and department heads regarding resident safety, neurological checks, abuse, neglect, and staff burnout. After 12/5/18, no staff, agency, or contracted staff will be allowed to work until the in-service is completed. The in-service with be added to new staff orientation, including agency and contracted staff. On 10/19/18, the DON, QI nurse or SF nurse began five day per week reviews of the nursing 24-hour report sheets for any new orders, notification of changes to the physician/NP in the progress notes, hypo/hyperglycemic episodes, neurological checks, and abuse/neglect. On 10/19/18, the administrator initiated multiple audit tools which will be completed by the administrative department heads (DON, QI nurse, SF, social worker, dietary, activities): the assistant dietary manager, activity director, and weekend manager-on-duty will complete supervision observations utilizing the Administrative Rounds tool, the social worker will complete weekly interviews with interviewable residents to	

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F 835	Continued From page 133 Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to administer insulin per physician order's which caused the resident to be sent out to the hospital with diabetic ketoacidosis (DKA), a serious complication of diabetes, for 1 of 3 residents reviewed with insulin dependent diabetes (Resident #2). 5. This tag is cross referred to F 760: Based on observations, record review, resident, staff, and Nurse Practitioner interviews, the facility failed to administer physician ordered insulin medication to keep residents free of significant medication errors in accordance with accepted professional standards and principles for 1 of 3 residents reviewed for pharmacy services (Resident #2). An interview conducted on 10/23/18 at 11:45 AM with the Director of Nursing (DON) revealed she was new to the facility and had been the DON for approximately two months. She stated she felt like there was facility wide breakdown in communication and education and that was the cause for the system failures that caused the deficient practice. An interview conducted on 10/23/18 at 11:55 AM with the Administrator revealed there had been a lack of communication between staff, administration, and the physician. She stated education needed to be provided to make sure facility policies and procedures were being followed so residents could be kept safe and appropriate care provided. On 10/11/18 at 3:49 PM the Director of Nursing	F 835	ensure no abuse occurred. QI nurse/unit manager will complete five times per week the Insulin Audit Tool to ensure diabetic residents are receiving insulin as ordered by the physician and medication is available. On 10/22/18, the administrator, other department heads and corporate facility consultants began meeting during the interdisciplinary team (IDT) meeting to perform a root cause analysis using the 5-Whys process. Communication as evidenced by lack of information and lack of access to needed resources has been determined to be the root cause of why the facility failed to have resources and processes in place to administer basic nursing care and resident treatment to promote resident well-being. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur: On 10/11/18 □ 10/15/18, the corporate nurse consultants mentored the administrator, DON, QI nurse and SF on where to find and access corporate policies, procedures, and action checklists. The corporate nurse consultants also assisted with drafting in-services to include: falls, neurological checks, blood glucose monitoring, insulin administration, and abuse/neglect. The purpose was to instruct facility staff to provide basic nursing care and treatment to residents in a manner which promotes well-being and respect. On 10/19/18, the DON, the QI nurse, and	

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F 835	Continued From page 134 and the Corporate Consultant were notified of Immediate Jeopardy for Resident # 20. On 10/18/18 administration was notified of additional immediate jeopardy for Resident # 2 and # 3. On 10/22/18 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: Macon Valley Nursing and Rehabilitation Center was placed into Immediate Jeopardy on October 19, 2018. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/11/18, Nurse #4 failed to follow the physician's order by not administering insulin to Resident #2 as prescribed. On 9/12/18, Resident #2's blood glucose level continued to register as "HI"; the nurse practitioner gave an order to send Resident #1 to the hospital. The director of nursing (DON) failed to effectively implement training and monitoring processes to maintain Resident #2's highest practicable physical well-being. On 9/22/18, Nurse #1 and Nurse #2 failed to initiate neurological checks and properly inform the physician of Resident #20's change in condition after a fall. The DON failed to effectively implement training and supervision to ensure basic care was provided to attain Resident #20's highest practicable well-being. On 10/1/18, nursing assistant (NA) #1 abused Resident #3 when NA #1 held the resident to keep the resident from leaving the bathroom	F 835	SF nurse initiated an education to set the DON□s expectation for all registered nurses (RNs), and licensed practical nurses (LPNs). The expectation is blood glucose monitoring and insulin administration as ordered by the physician, checking the emergency drug kit (EDK) for a backup, and notification of the physician/NP. On 10/19/18, the administrator, DON, QI nurse, SF, Vice President of Operations and/or corporate consultant will review and analyze the audit tool results weekly, for six months to validate the facility has provided each resident with the means to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The administrator, DON, vice president, and/or corporate consultant will initial the bottom right corner of the audit tools with the date as validation of review. On-going mentoring with the administrator and administrative team will continue to be provided by the Vice President of Operations and/or consultant team at a minimum of at least monthly. On 10/20/18 and 10/22/18, the Vice President of Operations contacted the Quality Improvement Organization (QIO) and requested mentoring assistance monitoring recommendations. On-going mentoring will also be provided to the administrator and administrative team by the QIO beginning 10/26/18 during a facility visit. On 10/21/18, the corporate nurse consultant provided information on how a	

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F 835	Continued From page 135 during incontinent care. NA #8 failed to follow the abuse policy when NA #8 did not intervene and immediately report NA #1's abuse of a resident. On 10/11/18 upon notification of abuse, the DON ensured Resident #3 was safe and initiated an abuse investigation. Upon completion of the investigation, the DON determined quality of life, quality of care, and resident abuse issues occurred due to staff not being properly trained, lack of supervision, and staff burnout. On 10/11/18 - 10/19/18, the DON and quality improvement (QI) nurse audited Resident #20's and Resident #2's medication administration record (MAR) and nursing progress notes, inspected the emergency drug kit (EDK), reviewed neurological checks, and interviewed nurses. The DON identified effective systems were not in place to maintain Resident #20's and Resident #2's highest practicable physical, mental, and psychosocial well-being. The reviews and audits revealed communication breakdowns within the nursing department created deficiencies in facility practices related to training on policies, following physician orders, notifying physician of changes, medication errors, and providing basic nursing care which neglected Resident #20's, and Resident #2's well-being. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/19/18, the DON and staff facilitator (SF) initiated multiple in-services for 100% of appropriate staff to include RNs, LPNs, nursing assistants, geriatric care assistants, agency staff, housekeeping, laundry, dietary, therapy, and department heads regarding resident safety,	F 835	utilization of the cause and effect 5 Whys Root Cause Analysis (RCA) will be used to help the facility uncover the real causes for showers not being offered, incontinent care not provided, falls, neurological checks, blood glucose monitoring, insulin administration, and abuse/neglect to promote resident well-being and respect. The IDT and the QI committee will use the provided information and root cause analysis tools to drill down to identify areas needing improvement. On 10/22/18, the administrator will begin working with the QIO to implement effective leadership and management to seek guidance on how changes leadership can make to implement a safe, healthy, and respectful environment for the residents. 4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when correction action will be competed). Beginning 10/11/18, the facility increased communication in the form of: verbal communication during in-services and daily interdisciplinary team (IDT) meetings, written education, posted reminders, and audit forms to ensure the facility provides residents with: medications as ordered, basic nursing care, dignity and respect and the means to resident well-being. The IDT, QI and QAPI committees will continue to monitor the facility to identify other factors causing the failure to communicate issues related stemming from training, staffing, basic nursing care, abuse/neglect, or	

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F 835	Continued From page 136 neurological checks, abuse, neglect, and staff burnout. After 10/19/18, no staff, agency, or contracted staff will be allowed to work until the in-service is completed. The in-service with be added to new staff orientation, including agency and contracted staff. On 10/19/18, the DON, QI nurse or SF nurse began five day per week reviews of the nursing 24-hour report sheets for any new orders, notification of changes to the physician/NP in the progress notes, hypo/hyperglycemic episodes, neurological checks, and abuse/neglect. On 10/19/18, the administrator initiated multiple audit tools which will be completed by the administrative department heads (DON, QI nurse, SF, social worker, dietary, activities): the assistant dietary manager, activity director, and weekend manager-on-duty will complete supervision observations utilizing the Administrative Rounds tool, the social worker will complete weekly interviews with interviewable residents to ensure no abuse occurred. QI nurse/unit manager will complete five times per week the Insulin Audit Tool to ensure diabetic residents are receiving insulin as ordered by the physician and medication is available. On 10/22/18, the administrator, other department heads and corporate facility consultants began meeting during the interdisciplinary team (IDT) meeting to perform a root cause analysis using the "5-Whys" process. Communication as evidenced by lack of information and lack of access to needed resources has been determined to be the root cause of why the facility failed to have resources and processes in place to administer basic nursing care and resident	F 835	supervision issues. Beginning 10/19/18, the DON, and QI nurse will present the in-service/mentoring comments, supervision observations, and audit trends to the IDT and monthly QI committee for six months. The IDT and QI committee will focus on improving residents□ well-being, including the provision of medication as ordered and neurological checks through developing communication. The administrator and/or DON will present the daily IDT and monthly QI committee recommendations to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance. The QAPI committee will continue consulting with the QIO until substantial compliance is achieved. The administrator will be responsible for implementing this plan of correction to ensure any issues of failure to provide a resident with dignity and respect or promote well-being will be addressed through additional root cause analysis, process correction, training, and monitoring.	

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treatment to promote resident well-being.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur:
On 10/11/18 - 10/15/18, the corporate nurse consultants mentored the administrator, DON, QI nurse and SF on where to find and access corporate policies, procedures, and action checklists. The corporate nurse consultants also assisted with drafting in-services to include: falls, neurological checks, blood glucose monitoring, insulin administration, and abuse/neglect. The purpose was to instruct facility staff to provide basic nursing care and treatment to residents in a manner which promotes well-being and respect.
On 10/19/18, the DON, the QI nurse, and SF nurse initiated an education to set the DON's expectation for all registered nurses (RNs), and licensed practical nurses (LPNs). The expectation is blood glucose monitoring and insulin administration as ordered by the physician, checking the emergency drug kit (EDK) for a backup, and notification of the physician/NP.

On 10/19/18, the administrator, DON, QI nurse, SF, Vice President of Operations and/or corporate consultant will review and analyze the audit tool results weekly, for six months to validate the facility has provided each resident with the means to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The administrator, DON, vice president, and/or corporate consultant will initial the bottom right corner of the audit tools with the date as validation of review. On-going mentoring with the administrator and administrative team will continue to be provided by the Vice President of Operations and/or consultant team at a minimum

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of at least monthly. On 10/20/18 and 10/22/18, the Vice President of Operations contacted the Quality Improvement Organization (QIO) and requested mentoring assistance monitoring recommendations. On-going mentoring will also be provided to the administrator and administrative team by the QIO beginning 10/26/18 during a facility visit.
On 10/21/18, the corporate nurse consultant provided information on how a utilization of the cause and effect (fishbone) diagram, Pareto chart, and/or "5 Whys" Root Cause Analysis (RCA) will be used to help the facility uncover the real causes for showers not being offered, incontinent care not provided, falls, neurological checks, blood glucose monitoring, insulin administration, and abuse/neglect to promote resident well-being and respect. The provided information and root-cause analysis tools will be used by the IDT and the QI committee to drill down to identify areas needing improvement.
On 10/22/18, the administrator will begin working with the QIO to improve effective leadership and management and seek guidance on how changes leadership can make to implement a safe, healthy, and respectful environment for the residents.

4. How the facility plans to monitor its performance to make sure solutions are sustained (include dates when correction action will be competed).
Beginning 10/11/18, the facility increased communication in the form of: verbal communication during in-services and daily interdisciplinary team (IDT) meetings, written education, posted reminders, and audit forms to ensure the facility provides residents with: medications as ordered, basic nursing care,

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dignity and respect and the means to resident well-being. The IDT, QI and QAPI committees will continue to monitor the facility to identify other factors causing the failure to communicate issues related stemming from training, staffing, basic nursing care, abuse/neglect, or supervision issues.
Beginning 10/19/18, the DON, and QI nurse will present the in-service/mentoring comments, supervision observations, and audit trends to the IDT and monthly QI committee for six months.
The IDT and QI committee will focus on improving residents' well-being, including the provision of medication as ordered and neurological checks through developing communication. The administrator and/or DON will present the daily IDT and monthly QI committee recommendations to the quarterly QAPI committee for additional recommendations for monitoring and continued compliance. The QAPI committee will continue consulting with the QIO until substantial compliance is achieved.
The administrator will be responsible for implementing this plan of correction to ensure any issues of failure to provide a resident with dignity and respect or promote well-being will be addressed through additional root cause analysis, process correction, training, and monitoring.
Macon Valley alleges compliance of removal of IJ as of 10/22/18.

On 10/23/18 facility staff were interviewed and demonstrated they had been trained on QI. Immediate jeopardy was removed effective 10/22/18.