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	345128	A. BUILDING _____ B. WING _____	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §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	F 656		4/19/19

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

Electronically Signed | 04/15/2019

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a comprehensive care plan (Resident #4) and implement a comprehensive care plan (Resident #5) for 2 of 4 residents reviewed for range of motion, contractures and positioning. The findings included: 1. Resident #4 was readmitted to the facility on 1/25/18 with medical diagnoses inclusive of Alzheimer's Disease, contracture of right knee and contracture of left knee, and unspecified osteoarthritis. A review of Resident #4's quarterly Minimum Data Set (MDS) dated 3/5/19 revealed Resident #4 was coded as cognitively impaired with impaired ROM to both lower extremities. A review of Resident #4's medical record revealed an order dated 02/26/19 for 4 weeks of physical therapy for 3 to 5 days per week for contractures. Review of the facility device record dated 11/13/18 included a start date of 12/1/18 to apply knee extension splints 6-8 hours per day when in bed. Record indicated splinting time will vary as resident's sleep/wake cycle and time out of bed varies. A review of Resident #4' care plan dated 3/19/19 revealed the resident had no care area identified	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 656 Develop/Implement Comprehensive Care Plans CFR(s): 483.21(b)(1) " The corrective action for the residents found to have been affected by the deficient practice 1. Resident #4 Splints were added to the care plan 2. Resident #5 Splints were added to point of care to ensure the certified nursing assistants document when the splints are on and when they are off " The facility will review and identify any other residents having the potential to be affected by the same deficient practice 1. Current residents with splints were reviewed by the MDS coordinator and the interdisciplinary team on March 25, 2019 and the care plans were reviewed and revised and when to put the splints on and remove was place in point of care (POC) for Certified nursing assistant documentation. 2. On March 25, 2019 the MDS	

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F 656	Continued From page 2 for range of motion, contractures, splinting or positioning. An observation was made on 3/20/19 at 3:53 PM of Resident #4 lying in bed with his eyes closed. Resident #4's legs were severely contracted at the knee joint. Knee extension splints were observed to be next to her closet. Observations were also made on 3/21/19 at 11:20 AM and 3/22/19 at 11:05 AM of Resident #4 lying in bed with knee extension splints next to her closet. An observation was made with the Physical Therapist Assistant (PTA) of Resident #4 lying in bed with her eyes closed on 3/22/19 at 11:30 AM. The PTA reported the resident should be wearing bilateral knee extension splints while in bed. The PTA observed the device record with a picture in Resident #4's closet door dated 11/13/18. The PTA reported the device record posted had not been updated with new instructions for applying the splints. The PTA also stated the device record in the splint binder at the nursing station needed to be updated as it was the same record posted in Resident #4's closet door. The PTA stated a therapist or therapist assistant provided the nursing staff the device record to post and place in splint binder. The PTA did not indicate who was responsible for updating the splint binder and the posted device record in Resident #4's closet. An interview on 3/21/19 at 2:45 PM with Nurse #2, a unit manager, revealed the resident care specialist assignment sheet identified individualized care needs for each resident. Nurse #2 stated the application of splints/brace was indicated under special needs/instructions.	F 656	coordinator and interdisciplinary team were re-educated on reviewing and revising care plans with changes in care regarding the use of splints by the regional nurse consultant. " The facility will begin the monitoring processes and systemic changes to ensure plan of correction is effective on April 1, 2019 though August 1, 2019 : 1. The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents weekly including the weekend, with orders for splints/braces to ensure that it is implemented /applied as ordered This will be done on a weekly basis to include the weekend for 4 weeks then monthly for 3 months " The facility plans to monitor its performance to make sure that solutions are sustained by: 1. Effective April 1, 2019 the MDS Coordinator and director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance Date of compliance April 19, 2019	

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F 656	Continued From page 3	F 656		

She indicated therapist instruct nursing on applying splints/brace and the instructions would be indicated on the resident's care plan and the resident care assignment sheet.

An interview on 3/22/19 at 4:24 PM with the MDS Coordinator, revealed she had coded Resident #4 with receiving physical therapy services on the quarterly MDS. The MDS coordinator stated a focus area for application of splint/brace was not always placed on the care plan. The MDS Coordinator reported device/rehabilitation/activities of daily living (ADL) did not trigger on Resident #4's significant change MDS and therefore nursing judgement determined no focus area for ADLs and splints on the care plan.

An interview on 3/22/19 at 4:40 PM with the Director of Nursing (DON) revealed her expectation was for care plans to include a focus area related to splint/brace application when a resident received services in a functional therapy program implemented by nursing. The DON stated the focus area for splint/brace should be a collaboration with nursing and therapy on the resident's care plan.

2. Resident #5 was admitted to the facility on 1/26/18 with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction (Stroke) affecting left non-dominant side, Unspecified Dementia without Behavioral Disturbance, Generalized Muscle Weakness and Contracture of left hand.

Review of the most current Minimum Data Set (MDS) Assessment dated 1/10/19 and coded as an annual assessment indicated that Resident #5

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F 656	Continued From page 4	F 656		

was severely cognitively impaired. The MDS further indicated that Resident #5 required extensive assistance for bed mobility and transfers. Resident #5 was also coded as having impairment on one side for both upper and lower extremities. Further review of the MDS revealed Occupational Therapy (OT) provided treatment to Resident #5 from 5/1/2018 to 7/10/2018.

Review of Resident #5's care plan updated on 2/5/19 revealed Resident #5 was receiving Restorative Care: Splint/Brace Assistance to right and left hands. The goal was listed as follows: Resident #5 will tolerate the donning of splints daily through the next review date. The following intervention was listed: Don left splint on the 7:00 AM to 3:00 PM shift up to 6 hours as patient tolerates.

Multiple observations of Resident #5 on 3/20/19 (11:20 AM, 2:26 PM, 3:45 PM), 3/21/19 (7:24 AM, 8:09 AM, 8:57 AM, 11:10 AM) & 3/22/19 (10:17 AM) revealed no splint to Resident #5's left hand.

Interview with Nursing Assistant (NA) #2 on 3/20/19 at 3:30 PM revealed NA #2 did not apply a splint to Resident #5's left hand on 3/20/19. NA #2 stated the Physical Therapy Assistant (PTA) applied the left-hand splint to Resident #5 in the evenings. NA #2 further stated the resident care sheet guided her care for the residents daily but admitted that she had not looked at it that day when she failed to show a copy of the resident care sheet.

Interview with the PTA on 3/20/19 at 3:36 PM indicated the NA's were responsible for applying the splint to Resident #5's left hand on first shift. The PTA stated therapy posted instructions inside

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Resident #5's closet door when the restorative program ended regarding the application of his splint.

An observation of Resident #5 was done on 3/20/19 at 3:45 PM. No splint was noted to the left hand at this time. The closet door was also inspected with NA #2 for the presence of the instructions regarding the application of the splint. No instructions were noted inside the closet door. NA #2 did not know why the instructions regarding the splint application was not in the closet.

NA #6 was interviewed on 3/20/19 at 3:48 PM. NA #6 stated she did not know anything about Resident #5's splint.

Interview with NA #4 on 3/22/19 at 1:56 PM confirmed NA #4 did not apply a splint to Resident #5's left hand on 3/22/19. NA #4 further stated she was not sure about when the left-hand splint was supposed to be applied and for how long. NA #4 did not know about the instructions regarding splint application in the closet door. In addition, NA #4 stated Resident #5 had four room changes since January 2019.

Interview with the Occupational Therapist (OT) on 3/22/19 at 3:09 PM revealed Resident #5 was discharged from OT Services on 7/10/18 to the care of the Restorative Nursing Assistants. The OT further stated the Restorative Nursing Program only ran for 12 weeks, and then the care of Resident #5 regarding his left-hand splint was switched over to the NAs, who were then responsible for putting the splint on for Resident #5. After reviewing the resident care sheet, the OT noted that the application of splints was not

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F 656	Continued From page 6 indicated in the sheet. The OT stated that the NAs would not know that Resident #5 required a left resting hand splint if it was not indicated in the resident care sheet. Interview with the Minimum Data Set (MDS) Coordinator on 3/22/19 at 3:30 PM revealed she updated Resident #5's care plan on 2/5/19. The MDS Coordinator stated it was the responsibility of the unit managers to make sure the care plan was implemented. Unit Manager #2 was interviewed on 3/21/19 at 12:05 PM. Unit Manager #2 stated she thought therapy was responsible for applying the splints on Resident #5. She further stated she was not aware that the restorative program for Resident #5 regarding splint application has already ended. Unit Manager #2 indicated she was responsible for updating the resident care sheets, and that she would have included the application of the left-hand splint on Resident #5's care sheet if she knew the restorative program has already ended. Interview with the Director of Nursing (DON) was conducted on 3/22/19 at 10:31 AM. The DON stated that on Resident #5's care plan, it was specified that the nursing department was responsible for putting the splints on. She said the nurses were supposed to document daily on the Medication Administration Record (MAR) that they checked to make sure they were on. But she was not sure if the application of the splints was also being documented by the NAs on the kiosk. She was not aware that the NAs did not have directions regarding the application of Resident #5's splints on the resident care sheets.	F 656		
F 688	Increase/Prevent Decrease in ROM/Mobility	F 688		4/19/19

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F 688 SS=E	Continued From page 7 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply bilateral knee extension splints (Resident #4) and a hand splint (Resident #5) for 2 of 4 residents reviewed for range of motion, contractures and positioning. The findings included: 1. Resident #4 was readmitted to the facility on 1/25/18 with medical diagnoses inclusive of Alzheimer's Disease, contracture of right knee and contracture of left knee, and unspecified osteoarthritis. A review of Resident #4's most recent quarterly MDS (Minimum Data Set) dated 3/5/19 revealed Resident #4 was identified as cognitively impaired	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) " The corrective action for the residents found to have been affected by the deficient practice 1. Resident #4: bilateral knee splints applied per plan of care and as indicated in the Point of Care documentation per physician orders. 2. Resident #5: hand splint applied per plan of care and as indicated in the Point of care documentation per physician orders. " The facility will review and identify any	

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F 688	Continued From page 8 and having impaired range of motion of both lower extremities. A review of Resident #4's medical record revealed an order dated 2/26/18 for 3 to 5 days per week for 4 weeks of physical therapy for evaluation of bilateral contractures. A review of Resident #4's physical therapy treatment encounter discharge note written by the physical therapist assistant (PTA) dated 3/7/19 at 3:51 PM revealed the nurse aide was able to demonstrate fair understanding of the splinting technique and schedule. The instructions were dated 3/8/19 and indicated staff were to apply the bilateral knee extension splints while Resident #4 was in bed. An observation was made on 3/20/19 at 3:53 PM of Resident #4 lying in bed asleep. Resident #4 legs were severely contracted at the knee joint. Knee extensions splints were observed to be next to her closet. Observation were made on 3/21/19 at 11:20 AM and 3/22/19 at 11:05 AM of Resident #4 lying in bed. Observations revealed knee extension splints were next to her closet. A device record dated 11/13/18 included a start date of 12/1/18 to apply knee extension splint 6-8 hours per day when in bed. Record indicated splinting time will vary as resident's sleep/wake cycle and time out of bed varies. An observation of Resident #4 lying in bed was made with a physical therapist assistant (PTA) on 3/22/19 at 11:30 AM. The PTA reported the resident should be wearing bilateral knee extension splints while in bed. The PTA observed	F 688	other residents having the potential to be affected by the same deficient practice 1. On March 27, 2019 the Director of Nursing, Quality, Therapy Director, Unit Manager and Minimum Data Set Coordinators reviewed all current residents with splinting / brace devices for contractures management to ensure that they were applied per physician orders by nursing department (Registered nurses RN, Licensed Practical Nurses LPN and Certified nursing assistant CNA) 2. On March 29, 2019 the Director of Nursing and Unit Manager in serviced the Nurses (RN and LPN) and Nurse Aides (Full time, Part time, and PRN) that The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident□s clinical condition demonstrates that a reduction in range of motion is unavoidable and A resident with limited range of motion receives appropriate treatment and services to increase range of motion and /or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Splints/Braces must be applied per physician orders.	

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F 688	Continued From page 9 the device record with a picture in Resident #4's closet door dated 11/13/18. The PTA reported the device record posted had not been updated with new instructions for applying the splints. The PTA also stated the device record in the splint binder at the nursing station needed to be updated as it was the same record posted in Resident #4's closet door. The PTA stated a therapist or therapist assistant provided the nursing staff the device record to post and place in splint binder. An interview on 3/22/19 at 11:45 AM with the nurse aide (NA) assigned to Resident #4 on for the first shift (7:00am to 3:00pm), NA #1 stated she identified the needs of her assigned residents by referring to the resident care specialist assignment sheet. The sheet dated 3/22/19 did not identify applying bilateral knee extension splints for Resident #4. NA #1 stated she had been educated by physical therapy regarding applying bilateral splints for Resident #4 but indicated she was not aware when the knee extension splints were to be placed on Resident #4. NA#1 stated she understood therapy was responsible for updating the device record in binder and the posting on the resident's closet door. During an interview on 3/22/19 at 11:50 AM with Nurse #1 (Unit Manager), she reported therapy was responsible for instructing nurse aides on application of devices for residents and informing nurse aides of changes in devices and scheduling. Nurse #1 reported therapy had the responsibility of updating the device records in the splint binder and posting the record in the resident's closet. Nurse #1 stated the resident care specialist assignment sheet was updated	F 688	" The facility will begin the monitoring processes and systemic changes to ensure plan of correction is effective on April 1, 2019 through August 1, 2019: 1. The Director of Nursing and/or Minimum Data Set Coordinators will review 5 residents weekly including the weekend, with orders for splints/braces to ensure that it is implemented /applied as ordered This will be done on a weekly basis to include the weekend for 4 weeks then monthly for 3 months " The facility plans to monitor its performance to make sure that solutions are sustained by: 1. Effective April 1, 2019 the director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance Date of compliance April 19, 2019	

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F 688	Continued From page 10	F 688		

every day based on current care needs for each resident.

During an interview on 3/22/19 at 12:00 PM the PTA provided documentation of training regarding a functional maintenance program for Resident #4 dated 3/7/19. Resident #4 instructions included bilateral lower extremity noted the signature indicated those trained had a copy of any applicable handouts. The PTA provided the binder information and a device record dated 3/8/19 with the same date for staff to begin applying the splints while the resident was in bed. The PTA placed a copy of the device record dated 3/8/19 in the binder and posted the record in Resident #4's closet at that time.

During an interview with the Director of Rehab services on 3/22/192:52 PM, the Director stated he expected following discharge, therapist should provide education for functional therapy program to be carried out by nursing. The Director indicated providing pictures for nursing staff to post in the resident's closet was an extra step. The Director explained the functional therapy program was established to prevent further decline of contractures and the outcome of not wearing splints would be further contractures and possible skin breakdown.

During an interview with the Director of Nursing on 3/22/19 at 2:58 PM, the DON stated her expectation was that once education had been provided by therapy, the nursing staff was expected to complete the task as instructed by the therapist.

2. Resident #5 was admitted to the facility on 1/26/18 with diagnoses of Hemiplegia and

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Hemiparesis following Cerebral Infarction (Stroke) affecting left non-dominant side, Unspecified Dementia without Behavioral Disturbance, Generalized Muscle Weakness and Contracture of left hand.

Review of the most current Minimum Data Set (MDS) Assessment dated 1/10/19 and coded as an annual assessment indicated that Resident #5 was severely cognitively impaired. The MDS further indicated that Resident #5 required extensive assistance for bed mobility and transfers. Resident #5 was also coded as having impairment on one side for both upper and lower extremities. Further review of the MDS revealed Occupational Therapy (OT) provided treatment to Resident #5 from 5/1/2018 to 7/10/2018.

Review of Physician Order dated 7/10/18 include the following: Left resting hand splint to be applied by nursing staff up to 6 hours per day as tolerated every day shift.

Review of Resident #5's care plan updated on 2/5/19 revealed Resident #5 was receiving Restorative Care: Splint/Brace Assistance to right and left hands. The following intervention was listed: Don left splint on the 7:00 AM to 3:00 PM shift up to 6 hours as patient tolerates.

A document entitled Resident Care Specialist Assignment Sheet dated 3/20/19 was reviewed for Resident #5, and it did not indicate for the Nursing Assistants (NA's) to apply the left-hand splint to Resident #5. The NA's used this sheet to guide the care they provided for the residents.

Resident #5 was observed on 3/20/19 at 11:20 AM pulling a splint out of his closet drawer with

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his right hand. Resident #5 did not move his left arm and his left hand was observed to be in a contracted position. Resident #5 did not have a splint to the left hand. An interview with Resident #5 was attempted at this time but Resident #5 did not respond to questions.

An observation of Resident #5 was done on 3/20/19 at 2:26 PM. Resident #5 was asleep while sitting in his wheelchair beside his bed. Resident #5 was noted leaning towards his left side. No splint was noted to the left hand at this time.

Interview with NA #2 was conducted on 3/20/19 at 3:30 PM. NA #2 stated that the left-hand splint on Resident #5 was applied in the evenings by the Physical Therapy Assistant (PTA). NA #2 confirmed that she did not apply a splint to Resident #5's left hand.

Interview with the PTA on 3/20/19 at 3:36 PM revealed the NAs were responsible for applying the splint to Resident #5's left hand on the 7 AM to 3 PM shift. The PTA further stated that Resident #5 was not on the Restorative caseload. The PTA said instructions regarding the application of the splint were posted inside Resident #5's closet door.

An observation of Resident #5 was done on 3/20/19 at 3:45 PM. Resident #5 was lying in bed. No splint was noted to the left hand at this time. The closet door was also inspected with NA #2 for the presence of the instructions regarding the application of the splint. No instructions were noted inside the closet door. NA #2 stated they had to print another copy of the instructions to put in the closet. NA #2 did not know why the

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instructions regarding the splint application was not in the closet.

Multiple observations of Resident #5 were made on 3/21/19 at 7:24 AM, 8:09 AM, 8:57 AM and 11:10 AM, and revealed Resident #5 did not have a splint to the left hand.

Interview with Unit Manager #2 on 3/21/19 at 12:05 PM indicated she thought therapy was responsible for applying the splints on Resident #5. Unit Manager #2 stated she was not aware that the restorative program has ended for Resident #5, and that there were no instructions in Resident #5's closet door for application of the left-hand splint. Unit Manager #2 further stated she was responsible for updating the resident care sheets which guided the care provided by the nursing assistants. Unit Manager #2 indicated that she would have included the application of Resident #5's left-hand splint if she had known that the Restorative Nursing Assistant no longer works with Resident #5.

An observation of Resident #5 on 3/22/19 at 10:17 AM revealed no splint noted to the left hand and Resident #5's left hand was observed to be in a contracted position.

Interview with NA #4 on 3/22/19 at 1:56 PM confirmed NA #4 did not apply a splint to Resident #5's left hand. NA #4 further stated she was not sure about when the left-hand splint was supposed to be applied and for how long. NA #4 said she was never instructed by Unit Manager #2 regarding the application of the splint to Resident #5. She further stated that Resident #5 has had four room changes since the date the splint was ordered.

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Interview with the Director of Nursing (DON) was conducted on 3/22/19 at 10:31 AM. The DON stated the NA's were responsible for applying the left-hand splint on Resident #5 after he was discharged from Restorative Care on 9/28/18. She further stated the NAs have been trained on the application of the splint by the Restorative Nursing Assistant prior to 9/28/18 but they did not keep a record of the training. She was not aware that the NAs did not have directions regarding the application of Resident #5's splint on the resident care sheets.

Interview with the Occupational Therapist (OT) on 3/22/19 at 3:09 PM revealed the purpose of the left resting hand splint on Resident #5 was to provide optimal joint alignment and to prevent further decrease in range of motion. Resident #5 was discharged from OT Services on 7/10/18 to the care of the Restorative Nursing Assistants. The OT stated at the time of Resident #5's discharge from therapy she filled out a Communication Form that specified the following instructions: left resting hand splint to be applied by Restorative Nursing Assistants via Restorative Nursing Program up to 8 hours per patient tolerance. Furthermore, the OT posted specific instructions regarding the application of the splint inside Resident #5's closet door. The OT further stated the Restorative Nursing Program only ran for 12 weeks, and then the care of Resident #5 regarding his left-hand splint was switched over to the NAs, who were then responsible for putting the splint on for Resident #5. After reviewing the resident care sheet, the OT noted that the application of splints was not indicated in the sheet. The OT further stated she did not receive any reports from the nursing staff about Resident

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F 688	Continued From page 15 #5 not tolerating the left-hand splint or Resident #5 refusing to have the left-hand splint applied. Interview with the Administrator was conducted on 3/22/19 at 5:16 PM. The Administrator agreed there was a breakdown in the communication of care regarding the application of splints on Resident #5. She further stated it was her expectation that splints should be applied as ordered. She expected the nursing staff to be held responsible for updating the care sheets and making sure the posted information in the closet door is updated and correct.	F 688		
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 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	F 690		4/19/19

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F 690	Continued From page 16 (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 interviews with facility staff and physician office staff and record review, the facility failed to follow a physician order for an antibiotic which delayed treatment for a urinary tract infection for 1 of 3 sampled residents reviewed for treatment of urinary tract infections (Resident #1). Findings included: Resident #1 was admitted to the facility on 11/15/17 with diagnosis including benign prostatic hyperplasia with lower urinary tract symptoms. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated 1/31/19 revealed the resident's cognition was severely impaired. Review of the medical record revealed the resident was evaluated by a physician assistant in the urology clinic on 2/12/19. During the evaluation a urine specimen was obtained for urinalysis and culture. Further review of the medical record revealed on	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) " The corrective action for the residents found to have been affected by the deficient practice 1. Resident #1 received antibiotic for urinary tract infection " The facility will review and identify any other residents having the potential to be affected by the same deficient practice 1. On March 25, 2019 the director of nursing/ unit coordinators/supervisors reviewed current residents with labs for urinalysis and cultures to determine if orders were received and placed in the electronic medical record. " The facility will begin the monitoring processes and systemic changes to ensure plan of correction is effective on April 1, 2019 through August 1, 2019.: 1. The Director of nursing/Unit coordinators/supervisors will review all faxed orders daily to ensure they are all	

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F 690	Continued From page 17 2/14/19 an order for Augmentin (antibiotic) one tablet twice a day for 14 days was written by the physician assistant and faxed to the facility on 2/14/19 at 11:04 AM. Review of the facility nurse practitioner (NP) notes revealed the resident was evaluated on 2/18/19 for a fever of 101 degrees F and noted that the resident had a history of multiple urinary tract infections (UTI) over the last couple months. An order dated 2/18/19 was written by the NP for urinalysis and culture. Review of resident's treatment record revealed the urinalysis and culture was obtained on 2/19/19 at 9:38 AM. On 2/20/19 the NP wrote an order for Keflex (antibiotic) 500 milligrams one tablet 2 times per day for UTI. Review of the resident's medication administration record revealed the first dose of Augmentin, ordered on 2/14/19, was not given until 2/20/19 at 9:00 PM. The order for Keflex was discontinued on 2/20/19 at 4:14 PM. An interview, conducted on 3/22/19 at 11:15 AM with Nurse #3, revealed Resident #1 started running a temperature on 2/18/19. Nurse #3 called the NP and got an order for a urinalysis and culture, which she obtained with straight catheter on 2/19/19 at 9:39 AM. Nurse #3 stated the process for starting an antibiotic for a resident is completed by the unit coordinator (UC). The UC needed to enter the order into the computer. The new order then showed up in the resident's medication administration record. Nurse #3 was not sure why the order for Augmentin, written on 2/14/19, was not started until 2/20/19. An interview, conducted on 3/21/19 at 1:15 PM	F 690	entered into the electronic record and on the medication administration record. 2. On March 29, 2019 the director of nursing re-educated the licensed nurses on monitoring the fax for orders and follow up on labs obtained. " The facility plans to monitor its performance to make sure that solutions are sustained by: 1. Effective April 1, 2019 director of nursing will report the findings of the audits and observations to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance Date of compliance April 19, 2019	

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with Nurse #2 (Unit Coordinator), revealed she believed the resident's son delivered the prescription to the Director of Nursing (DON) on 2/20/19. Nurse #2 stated she believed that she entered the order on 2/20/19, as delegated by the DON. However, she was not aware the order was written and faxed to the facility on 2/14/19. Nurse #2 further stated that when an order is faxed, a unit coordinator was responsible for entering the order into the computer on the same day. Once entered, the orders are automatically transmitted to the pharmacy. If the order was entered before 5:00 PM, the medication was delivered the same day. The facility kept Augmentin in stock and the nurse could go ahead and start administering. On 3/22/19 at 2:30 PM Nurse #2 stated she was not sure why she failed to process the order for Augmentin on 2/14/19, the date the order was written and faxed to the facility.

A phone interview, conducted with the urology clinic Office Manager (OM) and the facility DON on 3/22/19 at 9:40 AM, revealed an order for Augmentin was faxed to the facility on 2/14/19 at 11:04 AM with confirmation that the facility received the faxed order. The OM stated the facility was contacted on 2/14/19 at 4:07 PM to confirm the facility had received the faxed order for Augmentin. The physician assistant was not available for interview.

An interview, conducted with the Director of Nursing (DON) on 3/22/19 at 9:53 AM, revealed she thought the resident's son brought the order to the facility on 2/20/19. The DON stated she now knows the order, written and faxed to the facility on 2/14/19 was not acknowledged by the UC or processed until 2/20/19. The DON confirmed that faxed orders should be entered by

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F 690	Continued From page 19 the Unit Coordinator. She failed to identify why the faxed order for Augmentin, dated 2/14/19, was not processed until 2/20/19. The DON further stated that treatment should have started as soon as the facility received the order on 2/14/19. An interview, conducted with the Administrator on 3/22/19 at 5:15 PM, revealed she expected staff to initiate treatment as soon as the order was received.	F 690		