STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	C 07/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

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E 000	Initial Comments An unannounced recertification/complaint suvey was conducted on 07/15/19 through 07/20/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# 1NAU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted in the facility from 07/15/19 through 07/20/19. 21 of 52 complaint allegations were substantiated with federal deficiencies, and 3 of 52 complaint allegations were substantiated without deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		8/25/19

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

Electronically Signed | 08/08/2019

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F 580	Continued From page 1 (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). §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 observations, record review, and staff interviews, the facility failed to: 1) notify the physician regarding a positive x-ray result of a fractured humerus for 1 of 3 residents (Resident #45) observed for accidents and; 2) failed to notify the Responsible Party (RP) of medication changes for 1 of 7 residents (Resident #73) observed for unnecessary medications. Findings included:	F 580	Resident # 45 no longer resides in the facility. The Clinic Coordinator will review all current medications to include medication changes with resident # 73 resident representative by 8/25/19. On 8/5/19 100% audit of all x-ray reports from 7/1/19-7/31/19 was completed by the Director of Nursing to ensure abnormal x-ray reports to include fractures were reported to the provider upon receipt.	

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F 580	Continued From page 2 1) Resident #45 was admitted on 03/01/10. Diagnoses included, in part, cardiovascular disease, a fib, Alzheimer's, and a stroke with right sided weakness. A review of a progress note written by Nurse #2 on 07/14/19 at 7:56 PM revealed Nurse #2 was made aware by Nursing Assistant (NA) #1 that the bruise to the right upper extremity for Resident #45 was reported to NA #1 a few days ago by NA #2 from the night shift. The note indicated NA #2 informed NA #1 Resident #45 had a bruised shoulder of unknown origin. The note indicated NA #1 stated she had not worked with Resident #45 since then (07/12/19) until today (07/14/19) and noticed it was much more swollen. The progress note indicated NA #1 came and asked Nurse #2 about it and thought she should evaluate her because it looked so much worse than the last time she saw it. Nurse #2 noted she was not aware of this injury, but evaluated the resident and immediately reported it to her supervisor. Nurse #2 contacted the Nurse Practioner (NP) and obtained orders for a right shoulder x-ray and called the x-ray provider. A review of an x-ray of the right arm for Resident #45 taken on 07/14/19 and revealed Resident #45 had an acute fracture to the humeral head and neck with impaction. An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 reported on 07/14/19, Sunday evening, Nurse #2 reported off to her and told her Resident #45 had a bruise on her right arm. Nurse #3 stated Nurse #2 informed her the x-ray technician would be coming at 8:00 PM and to wait for the results. Nurse #3 stated at 8:10 pm, the x-ray was	F 580	There were no additional concerns identified. On 8/5/19, 100% audit of all physician orders for the past 30 days was initiated by the Charge Nurse to ensure the resident/resident representative to include resident # 73 were notified of new orders to include medication changes. The Nurse Supervisor, assigned hall nurse, and Clinic Coordinator will address all concerns identified during the audit to include notification of the resident and/or resident representative. The audit will be completed by 8/25/19. On 7/15/19, 100% in-service was initiated by the Staff Facilitator with all nurses to include nurse #3 and the nurse in charge in regards to Assessment and Notification for Acute Changes with emphasis on immediately reporting acute changes to the physician to include abnormal x-ray reports. 100% in-service was initiated on 8/7/19 by the Staff Facilitator with all nurses in regards to Transcribing MD Orders to include but not limited to notification of the resident and/or resident representative for medication changes with documentation in the clinical record. In-services will be completed by 8/25/19. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Assessment and Notification for Acute Changes and Transcribing MD orders. 10% audit of all residents newly obtained x-ray reports, will be completed by the ADON, QA nurse and/or Clinic Coordinators to ensure abnormal x-ray reports were reported to the provider upon	

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F 580	Continued From page 3 completed and the results were called in to the nurse around 10:50 PM. Nurse #3 reported the result was a fractured right humerus. Nurse #3 stated shortly after the x-ray company called with the result, a fax was received. Once she obtained the faxed result, she reported it to the Night Shift Charge Nurse (NSCN) and she waited to see what the NSCN was going to do. Nurse #3 stated she believed the NSCN called the DON and the RP. An interview with the night shift charge nurse (NSCN) was conducted via phone on 07/20/19 at 6:45 AM. She stated on the morning of 07/14 during the night shift, Sunday, she was made aware of Resident #45 by NA #21 who stated the resident had a bruise on her arm and NA #2, who was nearby, stated she told the nurses a few days ago. The NSCN stated once she learned of it, she was told it had been reported to other nurses so she thought the bruise was addressed. NSCN stated NA #21 told her it was yellowed. The NSCN reported when she came back to work that evening, the day supervisor had told her in the pre shift meeting that she looked into the injury of unknown origin and there was no documentation and found that nothing had been done about the bruise. The NCSN stated the NP was notified and an x-ray was ordered on 07/14/19. The NSCN stated she worked on a medication cart and had an assignment on a different hall from 7:00 PM - 11:00 PM on 07/14/19 when the x-ray result came in. The NSCN stated it was early morning when she realized the doctor had not been notified when she was speaking with Nurse #3 who stated she had given Tylenol to the resident. The NSCN questioned why just Tylenol was given for a fractured arm and Nurse #3 stated that was all	F 580	receipt utilizing the X-Ray Audit Tool. 10% audit of all new physician orders to include orders for resident # 73 will be completed by the ADON, QA nurse and/or Clinic Coordinators to ensure the resident/resident representative was notified of all new orders to include medication changes utilizing the Orders Audit Tool. Both audits will be completed weekly x 8 weeks then monthly x 1 month. The Clinic Coordinators, Nurse Supervisor and/or the ADON will address all areas of concern identified during the audit to include notification of the physician and/or resident/resident representative. The DON will review and initial the X-Ray audit tool and Orders Audit Tools weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the X-ray and Orders Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the X-ray and Orders Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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the resident had ordered. The NSCN said "Wait, did you call the Dr.?" and Nurse #3 said no, that they were waiting for the x-ray result and weren't sure what to do next. The NSCN stated she called the DON early in the morning on 07/15 and told her Resident #45 had a fractured arm and the DON asked if she was in pain. The NSCN stated no, she was resting comfortably and peaceful and the DON stated just go ahead and get the information ready for the doctor for when he comes in and we will send her out in the morning. The NSCN stated there must have been some miscommunication with who was going to call the doctor because she would have thought that Nurse #3 would have called the physician since it resulted while she (the NSCN) was on a medication cart with her own assignment.

An interview with NA #21 was attempted via phone on 07/20/19 at 10:45 AM. The phone number was disconnected. The DON was asked if there was another number and she reported the NA #21 was terminated and she had no other phone number for her.

An interview was conducted with Director of Nursing (DON) on 07/18/19 at 9:25 AM. The DON reported she was told by the NSCN she did not notify the physician because she thought the bruise was old and since the resident was not in any pain and was resting comfortably, they could send her out in the morning.

An interview was conducted with the facility physician on 07/18/19 at 4:15 PM. The physician stated when he came into the facility the morning of 07/15/19 and saw the x-ray result for Resident #45, he asked why the resident was still here and

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to get her to the ER now. The physician stated the staff noticed an injury on the resident, knew to get an x-ray to identify if anything was going on, obtained the result and saw that there was an abnormal result. The physician stated he would have expected the nurse to send the resident to the ER once she was made aware of the result. The physician stated if he was the doctor who received the call of an x-ray result with a fractured humerus, he would have ordered for the resident to be sent to the ER.

A review of a nursing progress note on 07/15/19 written by Nurse #4 revealed, in part, the resident remained in bed this morning (07/15/19) and the resident ' s right shoulder and upper arm was noted with swelling and bruising. The x-ray results of the right shoulder taken on 07/14/19 were reviewed by the physician on 07/15/19 and an order was received to send the resident to the Emergency Room (ER). At 10:30 AM, Resident #45 was sent to the hospital via Emergency Medical Services (EMS).

The DON reported her expectation of the nursing staff would have been for them to notify the physician right away regarding the fractured humerus. The DON stated the fractured humerus for Resident #45 was an acute change and the physician needed to be notified immediately.

2) Resident #73 was admitted to the facility on 06/16/15. Diagnoses included, in part, paranoid schizophrenia, depression and anxiety, and breast cancer with discharge (hyperprolactinemia).

A review of a progress note written on 12/10/18

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by the psychiatric physician revealed the resident was seen for follow up medication management. The note stated staff reported the resident was doing well with decreased behaviors and environmental complaints and the current medication appeared to be managing the resident's symptoms. The note indicated the resident has had nipple discharge (hyperprolactinemia due to elevated prolactin which was a hormone that tells the body to make breast milk) and it was discussed with the facility Nurse Practioner (NP) as this may be a side effect of an antipsychotic called Risperdal. The note stated the NP would order a prolactin level (a lab which indicated the amount of the hormone in the blood). The note stated the medication would remain prescribed until the lab results return.

A review of the physician orders revealed the current Risperdal order as of 12/10/18 was for 7 milligrams (mg) given by mouth two times per day for schizophrenia and also an order for Risperdal Consta 50 mg intramuscularly (IM an injection given via the muscle) every 14 days for schizophrenia.

A review of a progress note written on 12/21/18 by the psychiatric physician revealed the resident was seen on 12/21/18 due to a discussion with the NP that the resident was experiencing nipple discharge (hyperprolactinemia). A prolactin level of 18.6 Nano grams per milliliter (ng/ml) (normal was 18 ng/ml) was obtained and there was a discussion regarding Risperdal and that it could cause hyperprolactinemia. The note indicated the medication was lowered recently and there was a recommendation for gradual dose reduction (GDR) with a plan for discontinuation of

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the Risperdal as it was thought it was causing the nipple discharge. The recommendation was to decrease Risperdal to 2.5 mg two times per day and start Zyprexa (antipsychotic) 5 mg twice per day with a plan to discontinue Risperdal in 2 weeks with possible increase of Zyprexa as needed.

A review of a progress note written on 01/21/19 by the psychiatric physician revealed the resident was seen for follow up medication management. The note indicated the Responsible Party (RP) discussed the desire to restart the Risperdal despite the hyperprolactinemia. The current psychiatric medication order was to start the Risperdal 4 mg by mouth twice per day for schizophrenia with a plan to increase it back to 7 mg by mouth twice per day after 01/22/19 once the Zyprexa 5 mg by mouth every night until 01/22/19 was discontinued.

A review of the nursing notes from 12/10/19 through 12/21/19 revealed there was no documentation to support the RP was notified regarding medication changes with the antipsychotic medications.

An interview was conducted with the Director of Nursing (DON) on 07/17/19 at 2:30 PM. The DON reported the RP had come to her back in January 2019 regarding not being notified of the medication changes for Resident #73. The DON stated there was a care plan meeting and it was discussed that all medication changes needed to go through the RP going forward. The DON reported the RP reported the resident ' s behaviors were stable on the prescribed Risperdal and this medication worked best for him. The DON reported the policy and the

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F 580	Continued From page 8 expectation of the nurses was if there were any medication changes, the nurse on the shift that the medication change occurred was responsible for calling the RP.	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 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;	F 584		8/25/19

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F 584	Continued From page 9 §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 staff interview and observations the facility failed to maintain a safe, clean, comfortable, homelike environment: maintain 1 of 4 clean spa/shower rooms (400 hall spa/shower room). Findings included: On 07/17/19 at 3:55 PM the 400 hall Spa/shower room was observed. The entry door was closed, but not locked. On entrance in to the shower room immediately to the left was the spa tub. A soiled bed pad was wadded up inside the spa tub, with a shower chair on top of the tub. Inside the shower stall there were 2 used gloves and a used wash cloth on the floor, and multiple partially empty shampoo bottles sitting on the shower stall grab bars. On the floor inside of the shower stall was a couple of dime sized brown matter clumps. The top of the sink contained one used hair brush with hair in the bristles. On 07/17/19 at 4:00 PM a tour and interview was conducted with Nursing Aide (NA) #13. The NA revealed the 400 hall spa shower room was left unclean after the last resident shower on 07/17/19. Observation of the 400 hall Spa/shower room revealed there was a used washcloth and 2 dime sized dark matter debris on	F 584	On 7/17/19, the shower room on the 400 hall was cleaned by the nursing assistant and the housekeeping staff with oversight by the Director of Nursing. 100% observation of all shower rooms to include 400 hall will be completed by 8/25/19 by the Admissions Director to ensure shower rooms utilizing a shower audit tool. The housekeeping staff, assigned hall nurse and nursing assistants will address all concerns identified during the audit to include removal of soiled items and cleaning of shower room. 100% in-service was initiated by the Staff Facilitator on 8/7/19 with 100% nurses and nursing assistants regarding cleaning shower rooms with an emphasis on removal of dirty linen, removal of personal hygiene products, and removal of feces and urine in between resident□s showers. 100% in-service of Housekeeping Staff was initiated by the Staff Facilitator on 8/2/19 in regards to checking shower rooms daily during cleaning. A shower room cleaning schedule was provided to the Administrator on 8/2/19 by the Housekeeping Supervisor. All newly hired nurses, nursing assistants and	

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F 584	Continued From page 10 the shower stall floor, 5 individual resident shampoo bottles were left on she shower stall railing, a soiled bed chuck was left wadded up in the spa whirlpool tub which was covered by a shower chair, and no garbage can was observed in the shower room. NA #13 said the shower room should have been cleaned up after the last resident shower, and wasn't. The NA then gloved, and removed the dirty washcloth from the shower stall, used gloves room the floor, bed chuck from the tub, and placed the washcloth and chuck in a covered soiled linen container. On 07/17/19 at 5:10 PM a tour of the 400 hall spa/shower room was conducted with the facility Director of Nursing (DON). The DON revealed the 400 hall shower spa room was not clean. Observations revealed 2 dime sized dark matter chunks on the shower stall floor, resident shampoo bottles left on shower stall railing, and on top of the sink contained one used hair brush with hair in the bristles. DON stated the NAs were responsible to clean the shower room after each shower, and didn't. On 07/20/19 at 10:30 AM the facility administrator was interviewed. The administrator revealed that she was not aware of the spa/shower room concerns observed on 07/17/19 and the expectation was that all areas in the spa/shower rooms be clean and homelike.	F 584	housekeeping staff will be in-serviced during orientation by the Staff Facilitator regarding cleaning shower rooms. In-services will be completed by 8/25/19. The Admissions Director will monitor 100% of all shower rooms, to include 400 hall, for cleanliness weekly x 8 weeks then monthly x 1 utilizing a Shower Room Audit Tool. The Housekeeping Supervisor, assigned hall nurse or nursing assistant will address immediately any identified areas of concern during the audit. The Administrator will review the Shower Room Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The DON will present the findings of the Shower Room Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Shower Room Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 600 SS=G	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,	F 600		8/25/19

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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.

§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 staff interviews, physician interview and record review the facility neglected to seek medical treatment for a bruise of unknown origin that was identified to a resident's right upper extremity for 1 of 3 residents (Resident #45) reviewed for accidents. Staff observed a bruise on Resident #45's arm for 4 days before seeking medical treatment and obtaining an x-ray which showed the resident had a right humerus fracture.

Findings included:

Resident #45 was admitted on 03/01/10. Diagnoses included, in part, cardiovascular disease, atrial fibrillation, Alzheimer ' s disease, and a stroke with right sided weakness.

The Minimum Data Set dated 05/03/19 quarterly assessment revealed there was no cognitive assessment completed. Resident #45 exhibited no mood or behaviors. Resident #45 required extensive assistance with one staff physical assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and personal hygiene. Resident #45 was not

Resident # 45 no longer resides in the facility.
On 7/15/19, 100% head to toe assessments were completed on all residents with a BIMS of 0-12, 99 or not assessed for signs and symptoms of injury of unknown origin to include bruises by the hall nurses and clinical coordinators to ensure all areas have been investigated and addressed with completion of an incident report. There were no other identified areas of concerns during the audit.
On 7/15/19, 100% of all alert and oriented residents were questioned by the Social Workers with question regarding: Do you have any injuries or incidents that have not been reported and addressed? There were no concerns voiced during the interviews.
100% of all progress notes from 7/1/19 to 7/15/19 were reviewed by the Director of Nursing on 7/16/19 to identify documentation of injury of unknown origin and ensure all identified injuries have been investigated and addressed with

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steady and only able to stabilize with staff assistance. Resident #45 had impairments to both sides to upper and lower extremities and used a wheelchair. The resident was always incontinent of bowel and bladder and had no falls or skin concerns recorded. Resident #45 received no anticoagulants (blood thinners).

A review of the care plan for Resident #45 updated on 05/03/19 revealed there was a plan of care in place for at risk for skin breakdown related to impaired mobility and incontinence. Interventions included, in part, to inspect skin and notify nurse of abnormal changes. A plan of care for potential for skin tears related to fragile skin was in place with interventions to include, in part, observe skin daily and notify nurse of new skin tears, and a weekly evaluation/assessment with notification of physician of changes as necessary.

Medical record review revealed there were no issues documented that Resident #45 had any bruising on 07/09/19.

An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 stated no staff member had reported a bruise on Resident #45 ' s arm during the night shift on 07/09/19.

A weekly skin check assessment completed on 07/09/19 at 1:44 PM by Nurse #2 revealed the resident had a skin check done and the present skin integrity issue was the right toe with an intervention for lower extremity bridging/floating. The skin assessment did not indicate there was a bruise to the right upper extremity.

An interview was conducted with Nurse #2 on

completion of an incident report. There were no identified areas of concern.
100% of all incidents reports for unknown origin and bruises from 7/1/19-7/15/19 were reviewed by the Quality Assurance Nurse (QA) nurse on 7/16/19. This audit is to ensure that all identified injuries of unknown origin have been investigated, an assessment completed, and physician and resident representative notification has been completed.
100% in-service was initiated with all nursing assistants and nurses by the Staff Facilitator on 7/15/19 in regards to (1) Observation and reporting of changes in condition to include injury of unknown origin. The In-service will be completed by 7/17/19. After 7/17/19, the Staff Facilitator will mail the in-services via certified mail to any nursing assistant or nurse who has not received the in-service with instructions to review, sign the in-service, and return to the DON or Staff Facilitator prior to the next scheduled work shift. All newly hired nursing assistants and nurses will be in-serviced by the Staff Facilitator during orientation.
10% of all residents will be assessed by the QA Nurse weekly x 8 weeks then monthly x 1 month for signs and symptoms of injuries of unknown origin with documentation in the electronic medical record on the skin audit tool. This audit is to ensure that all identified injury of unknown origins has been reported, investigated, incident report completed, and the physician and resident representative has been notified. All areas of concern will be immediately

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F 600	Continued From page 13 07/18/19 at 11:59 AM. Nurse #2 reported when she completed the skin check assessment on 07/09/19 for Resident #45, she only identified the area on the resident ' s right toe. Nurse #2 stated she did not see a bruise on the resident ' s arm. An interview was conducted with Nursing Assistant (NA) #4 on 07/17/19 at 12:16 PM. NA #4 reported Resident #45 was on her assignment and she worked from 7:00 AM to 11:00 PM. NA #4 stated skin checks were usually done when a resident got a complete bed bath or shower. NA #4 stated Resident #45 would get her shower on the night shift early in the morning. NA #4 stated when she started her shift on 07/09/2019, the resident was already up and dressed and sitting up in the chair. NA #4 stated she transferred her to the bed to change her and she did not recall the resident showing any signs or symptoms of pain. NA #4 stated if she had seen a bruise, she would have notified the nurse immediately. Medical record review revealed there were no issues documented that Resident #45 had any bruising on 07/10/19. An interview was conducted with NA #3 via phone on 07/18/19 at 6:00 AM. NA #3 reported he worked the night of 07/10/19 going into 07/11/19. NA #3 reported Resident #45 was on his assignment and when he went to give her a bed bath and was undressing her, he noticed bruising on the right arm from the upper forearm area to the shoulder. NA #3 described the bruise as black and blue and purple and it covered the upper arm. NA #3 stated he told Nurse #1, and she told him that she would tell Nurse #4 because Nurse #1 was usually on the 500/600 hall. NA #3 stated Nurse #1 assessed the bruise. NA #3	F 600	addressed by the QA nurse to include re-training of staff during the audit. The DON will print, review, and initial the Skin Audit Tools weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The initial Quality Assurance (QA) meeting to review the plan of correction was held on 7/15/2019. The DON will forward the Skin Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the Skin Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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stated he finished giving Resident #45 her bath and kept her in bed. NA #3 reported the resident did not show any signs of pain like grimacing or moaning. NA #3 stated he left the resident in bed so the day nurse (Nurse #4) could look at her. NA #3 reported the resident did not try to get out of bed. She was cooperative with care and had no falls. He stated he did not know how the resident got the bruise and he was not aware of the bruise prior to starting his shift. He stated whenever he saw a change in condition be it skin, mental status, pressure ulcer, an abnormal vital sign or injury of unknown origin, the facility protocol was to notify the nurse.

An interview was conducted with Nurse #1 on 07/17/19 at 7:15 AM. Nurse #1 stated during the night shift on the night of 07/10/19 going into 07/11/19, NA #3 reported to her there was a bruise on Resident #45. Nurse #1 stated she assessed the bruise and noted it was on her right upper forearm and it was yellowish in color and about the size of her hand. Nurse #1 stated she moved the shoulder and arm around and the resident showed no signs or symptoms of pain. Nurse #1 stated she spoke with Nurse #4 on the day shift the morning of 07/11/19 because the bruise looked old to Nurse #1. Nurse #1 stated Nurse #4 stated she had no prior knowledge about a bruise on Resident #45. Nurse #1 reported that she was not told in report on the start of her shift on 07/10/19 going into 07/11/19 Resident #45 had a bruise. Nurse #1 stated after she assessed the bruise, she did not do anything else except report it to the oncoming nurse (Nurse #4).

Medical record review revealed there were no issues documented that Resident #45 had any

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bruising on 07/11/19.

An interview was conducted with Nurse #4 on 07/19/19 at 11:55 AM. Nurse #4 reported she recalled Nurse #1 reporting to her on the morning of 07/11/19 Resident #45 had a bruise. Nurse #4 stated she went and assessed the bruise and it was on her upper forearm and it was small and purple. Nurse #4 stated it was not yellow or green to indicate it looked old. Nurse #4 reported she looked at the bruise again later on her shift and the resident had no complaints of pain. Nurse #4 stated she did not report or document on it because it was so small.

An interview was conducted with NA #6 on 07/17/19 at 4:00 PM. NA #6 reported she was assigned to Resident #45 for the day shift on 07/11/19. NA #6 stated she did not see Resident #45 ' s arm on 07/11/19. NA #6 reported the night shift would get the resident up because she was on restorative therapy. NA #6 stated while caring for Resident #45 during her shift, the resident had no complaints of pain or signs or symptoms of pain. NA #6 stated no one had reported to her Resident #45 had a bruise on her arm.

An interview was conducted with the Restorative Aide (RA) on 07/19/19 at 2:00 PM. The RA reported she worked with Resident #45 when she was assigned as a restorative aide. She stated the resident was on restorative therapy for range of motion, transfers, and eating. The RA reported the resident was compliant with restorative therapy and would not refuse or resist care. She stated recently she had been working as a NA instead of a RA and had not done any restorative therapy on the resident. She stated when she did restorative therapy the resident was usually up

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and dressed when she came into the room in the morning. She stated the resident ' s restorative included range of motion of the upper extremities and included raising the resident ' s arms. The RA reported, at times Resident #45 could follow commands, but most of the time the RA performed the range of motion. The RA reported she tolerated the therapy well and had no signs of pain such as grimacing.

An interview was conducted with NA #7 via phone on 07/19/19 at 10:43 AM. NA #7 reported he was assigned to Resident #45 on 07/11/19 during the evening shift. NA #7 stated when he arrived, Resident #45 was already in bed and in her gown. NA #7 reported he did not see her arm throughout the shift and only did incontinent care on her.

An interview was conducted with Nurse #1 on 07/17/19 at 7:15 AM. Nurse #1 stated when she came in for her shift on 07/11/19 going into 07/12/19, she palpated the bruise and performed range of motion and the resident had no complaints of pain or any signs or symptoms of pain. Nurse #1 stated there was no change in the bruise on 07/12/19. Nurse #1 stated there was a policy in place for abuse and neglect which included injury of unknown origin, and if staff identified an injury of unknown origin, they were to notify the supervisor or Director of Nursing (DON) immediately, complete an incident report and an incident note, and notify the on call physician and the Responsible Party (RP). Nurse #1 stated she did not report it or document on it because it looked "old." Nurse #1 stated the bruise was faded and had yellow edges and she did not know how the resident got the bruise.

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Medical record review revealed there were no issues documented that Resident #45 had any bruising on 07/12/19.

An interview was conducted with NA #1 on 07/16/19 at 5:20 PM. NA #1 reported she had seen the bruise to Resident #45 ' s upper arm on 07/12/19 during the night shift. NA #1 reported NA #2 had asked her to come and look at Resident #45 ' s arm. NA #1 stated the right upper forearm was bruised. It was a large bruise and it was black and purple in color. NA #1 stated she told NA #2 to report it to the nurse.

An interview was conducted with NA #2 on 07/17/19 at 7:00 AM. NA #2 reported the early morning (night shift) staff was responsible for getting Resident #45 up and ready. NA #2 stated she worked the night shift on 07/12/19 and when she removed Resident #45 ' s robe, she noticed a bruise that was black and blue on the right upper forearm going up to her shoulder. NA #2 stated she did not see any open areas and the resident had no signs of pain. NA #2 stated she showed the bruise to NA #1 and NA #1 instructed her to report it to the nurse. NA #2 stated she covered the resident up and called Nurse #1 and stated she needed to come and see Resident #45. NA #2 reported Nurse #1 asked her if it was about the bruise and NA #2 said "yes." NA #2 stated Nurse #1 stated she was already aware of it because NA #3 had already informed her from a previous night. NA #2 reported that no staff member had reported anything about a bruise on Resident #45 to her. NA #2 stated she proceeded to get Resident #45 up and get her ready and put her in the chair. She stated the resident did not express any pain. She did not grimace or flinch. NA #2 stated the resident could

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not verbally make her needs known.

An interview was conducted with NA #6 on 07/17/19 at 4:00 PM. NA #6 reported she was assigned to Resident #45 for the day shift on 07/12/19. NA #6 stated she did not see Resident #45 ' s arm on 07/12/19. NA #6 stated while caring for Resident #45 during her shift, the resident had no complaints of pain or signs or symptoms of pain. NA #6 stated no one had reported to her Resident #45 had a bruise on her arm.

Medical record review revealed there were no issues documented that Resident #45 had any bruising on 07/13/19.

An interview was conducted with NA #7 via phone on 07/19/19 at 10:43 AM. NA #7 reported he was assigned to Resident #45 on 07/12/19 going into 07/13/19. NA #7 stated when he arrived at 7:00 PM, Resident #45 was already in bed and in her gown. NA #7 reported he did not see her arm throughout the shift and only did incontinent care on her. NA #7 stated NA #10 gave the resident her shower on the morning of 07/13/19.

An interview was conducted with NA #10 via phone on 07/19/19. NA #10 reported on the morning of 07/13/19 (during the night shift hours) she gave Resident #45 a shower. NA #10 stated the resident was brought into the shower room, she removed the splint she wore on her right arm, and she removed the resident ' s gown and gave her a complete shower. NA #10 reported she did not see a bruise on the resident ' s right arm. NA #10 stated if she had seen a bruise, she would have reported it to Nurse #3. NA #10 stated Nurse #3 did not do a skin check on Resident

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#45 because one had been done on 07/09/19. NA #10 stated she did not notice any bruising or swelling on Resident #45 and the only skin issue she observed was on her right toe.

An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 stated she worked from 7:00 PM - 7:00 AM on both 07/12/19 and 07/13/19 and no staff member reported to her a bruise on Resident #45.

Medical record review revealed there were no issues documented that Resident #45 had any bruising on 07/13/19.

An interview was conducted with NA #5 on 07/19/19 at 12:36 PM. NA #5 reported Resident #45, who was assigned to the resident on day shift on 07/13/19, wore a splint on her hand and a soft splint on her arm/elbow to keep the arm in place. He reported he did not really work with her that much on 07/13/19 except to do incontinent care. NA #5 stated she was already dressed and up when he started his shift and he was not made aware of a bruise on her arm. NA #5 reported the resident was smiling like she always does.

An interview with NA #21 who worked the evening shift and the night shift of 07/13/19 going into 07/14/19 was attempted via phone on 07/20/19 at 9:20 AM. The phone number was disconnected. The DON was asked if there was another number and she reported the NA #21 was terminated and she had no other phone number for her.

An interview with the night shift charge nurse (NSCN) was conducted via phone on 07/20/19 at 6:45 AM. She stated on Sunday morning on 07/14/19 during the night shift hours, she was

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made aware of Resident #45 by NA #21 who stated the resident had a bruise on her arm and NA #2, who was nearby, who stated she told the nurses a few days ago. The NSCN stated once she learned of it, she was told it had been reported to other nurses so she thought the bruise was addressed. NSCN stated NA #21 told her the bruise was yellowed. The NSCN stated she received training regarding abuse and the types of abuse which included neglect, and injury of unknown origin. The NSCN reported if there was an injury of unknown origin, the policy was to notify the physician right away, do an incident report, document, and call the family. The NCSN stated she did not report the bruise because she was told other nurses were aware of the bruise and she thought it had been addressed.

An interview was conducted with NA #1 on 07/16/19 at 5:20 PM. NA #1 stated on 07/14/19, she came in for the evening shift and was assigned to Resident #45. NA #1 stated she went into the resident ' s room to do her care and observed her arm. NA #1 stated it looked worse than it did on the 07/12/19. NA #1 stated when she looked at her arm, it looked swollen and the bruise was darker in color and had spread up to the shoulder. NA #1 stated she reported the bruise to Nurse #2 immediately. NA #1 stated Nurse #2 had not known anything about the bruise and stated this was the first time she had seen it. NA #1 stated the nurse got an x-ray on 07/14/19 and found out the right arm was fractured. NA #1 stated she took care of Resident #45 throughout the shift and she was comfortable through the night. NA #1 stated she did not grimace or flinch or show signs of pain when she did her care. NA #1 stated she did not know how the bruise happened. She reported

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the resident did not have a fall and she did not attempt to get out of bed. NA #1 stated she would stay in one position all day if you let her. NA #1 stated the resident was very quiet and would sometimes answer yes or no questions.

An interview was conducted with Nurse #2 on 07/18/19 at 11:59 AM. Nurse #2 reported on 07/14/19 at 4:00 PM she was taking care of another resident when NA #1 came up to her and asked her if she had seen Resident #45 ' s arm. Nurse #2 stated she said "no." Nurse #2 reported NA #1 stated it looked a lot worse than the other day and she would have thought the nurse would have heard about the bruise in report. Nurse #2 stated she went to the resident ' s room and removed her shirt and she had a huge bruise on her right arm. Nurse #2 stated she was "shocked!" Nurse #2 reported she left immediately and told the Day Supervisor (Day S/V) at the nurse ' s station. Nurse #2 stated the Day S/V was on the phone with the Nurse Practioner (NP) at this time so she told her to tell the NP about the bruise and that she needed an order for an x-ray. Nurse #2 stated she obtained the order to get the x-ray and the Day S/V notified the family. Nurse #2 stated she was resting in bed and had no signs or symptoms of pain. Nurse #2 stated NA #1 reported she saw the bruise on Resident #45 ' s arm a few days ago and it looked worse and that it was not swollen like it was today (07/14/19). Nurse #2 reported there was swelling and the bruise went from her forearm up to shoulder and was dark purple and green with yellowing edges and a lump in the upper forearm. Nurse #2 stated the resident did not appear to be in pain when she assessed the bruise.

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NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

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A review of a progress note written by Nurse #2 on 07/14/19 at 7:56 PM revealed Nurse #2 was made aware by NA #1 that the bruise to the right upper extremity for Resident #45 was reported to NA #1 a few days ago by NA #2 from the night shift. The note indicated NA #2 informed NA #1 Resident #45 had a bruised shoulder of unknown origin. The note indicated NA #1 stated she had not worked with Resident #45 since (07/12/19) until today (07/14/19) and noticed it was much more swollen. The progress note indicated NA #1 came and asked Nurse #2 about it and thought she should evaluate her because it looked so much worse than the last time she saw it. Nurse #2 noted she was not aware of this injury, but evaluated the resident and immediately reported it to her day supervisor, contacted the NP, obtained orders for a right shoulder x-ray, and called the x-ray provider.

An interview with the night shift charge nurse (NSCN) was conducted via phone on 07/20/19 at 6:45 AM. The NSCN reported when she came back to work that evening on 07/14/19, the Day S/V had told her in the pre shift meeting that she looked into the injury of unknown origin and there was no documentation found and nothing had been done about the bruise. The NCSN stated she was told by the Day S/V the NP was notified and an x-ray was ordered for 07/14/19.

An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 reported on 07/14/19, Sunday evening, Nurse #2 reported off to her and told her Resident #45 had a bruise on her right arm. Nurse #3 stated Nurse #2 informed her the x-ray technician would be coming at 8:00 PM and to wait for the results. Nurse #3 stated at 8:10 pm, the x-ray was

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completed and the results were called in around 10:50 PM. Nurse #3 reported the result was a fractured right humerus. Nurse #3 stated once she obtained the faxed result she reported it to the Night Shift Charge Nurse (NSCN) and she waited to see what the NSCN was going to do. Nurse #3 stated she believed the NSCN called the DON and the RP. Nurse #3 reported the resident did not have any signs or symptoms of pain, but once she obtained the x-ray results she medicated her with Tylenol because she could not verbalize she had pain and Nurse #3 wanted to make sure she was comfortable.

A review of an x-ray of the right arm for Resident #45 taken on 07/14/19 and revealed Resident #45 had an acute fracture to the humeral head and neck with impaction.

An interview was conducted with the Restorative Aide (RA) on 07/19/19 at 2:00 PM. The RA reported she had no knowledge of a bruise to her right extremity until she learned of the bruise on Monday, July 15, 2019, when she observed the resident in bed and her gown was hanging slightly off her shoulder and she saw the bruise. The RA reported she went to the nurse, but saw that the nurse was preparing to send her to the hospital because of the bruise so she did not report it to the nurse. The RA stated she did not look any closer at the bruise by removing the gown. She stated all she could see was black and blue with some yellow on the shoulder. The RA stated she did not touch the resident.

An interview was conducted with the facility physician on 07/18/19 at 4:15 PM. The physician stated when he came into the facility the morning of 07/15/19 and saw the x-ray result for Resident

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#45, he asked why the resident was still here and to get her to the ER now. The physician stated the staff noticed an injury on the resident, knew to get an x-ray to identify if anything was going on, obtained the result and saw that there was an abnormal result. The physician stated he would have expected the nurse to send the resident to the ER once she was made aware of the result. The physician stated it was unknown what had happened and when the bruising had actually occurred, but the nurse who first identified the bruising on 07/11/19 should have notified him and he would have had her sent to the ER if he was the physician on call. The physician stated he did not believe the fracture could worsen from 07/14/19 (when the x-ray showed a fracture) until 07/15/19 (when she was sent to the ER). The physician stated, however, no one actually knew when she fractured it or how.

An interview was conducted with Nurse #4 on 07/19/19 at 11:55 AM. Nurse #4 stated when she came back on Monday, 07/15/19, the bruise on the resident ' s arm was "way worse" than 07/11/19 and the x-ray showed there was a fracture. Nurse #4 stated she was sent to the emergency room (ER) that morning.

A review of the hospital record from 07/15/19 revealed in the summary of the history and physical, in part, resident presented with right humeral fracture of undetermined age, but probably occurred about 5 - 6 days ago given the size of the bruise which appeared to be old. The x-ray result indicated acute impacted displaced proximal right humerus fracture involving the right humeral head and neck and bones were osteoporotic and demineralized.

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F 600	Continued From page 25 A review of the hospital discharge summary on 07/19/19 indicated the resident had fracture of the right humerus approximately one week old. Orthopedics recommended non-surgical management with no need for splint and will use sling to limit right upper extremity movement. An interview was conducted with the SDC (Staff Development Coordinator) Nurse on 07/19/19 at 1:15 PM. The SDC nurse reported that all staff were oriented to the abuse policy and procedure upon hire, annually and as needed. The SDC nurse stated reporting an injury of unknown origin was included in the abuse training. The DON reported her expectation of the nursing staff would have been to assess the bruise once they were made aware of it, document their assessment, complete an incident report and report the concern to the physician, the DON and the RP so the management team could begin the investigation process for the injury of unknown origin. The DON reported the investigation process for the injury of unknown origin was initiated on 07/15/19.	F 600		
F 609 SS=E	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 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		8/25/19

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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, staff interviews, physician interview and record review the facility failed to report a right upper extremity bruise of unknown origin to the Director of Nursing and/or Administrator for 4 days for 1 of 3 residents (Resident #45) reviewed for accidents. After Resident #45 ' s bruise was reported an X-ray showed the resident had a fractured right humerus.

Findings included:

Resident #45 was admitted on 03/01/10. Diagnoses included, in part, cardiovascular disease, atrial fibrillation, Alzheimer ' s disease, and a stroke with right sided weakness.

The Minimum Data Set (MDS) dated 05/03/19 quarterly assessment revealed there was no cognitive assessment completed but she

Resident #45 no longer resides in the facility
On 8/7/19, the Assistant Director of Nursing initiated a 100% audit of all resident progress notes and incident reports from 7/1/19 to 7/15/19 to ensure all injuries to include bruises were reported timely to the Director of Nursing, Administrator, resident representative, and physician and that all injuries of unknown origin are reported in accordance with State Law. The Quality Assurance (QA) nurse and Director of Nursing (DON) will address all concerns identified during the audit. Audit will be completed by 8/25/19.
On 7/15/19, the Staff Facilitator initiated an in-service with 100% of nurses to include nurse #1 and nurse #3 in regards

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F 609	Continued From page 27 exhibited no mood or behaviors. Resident #45 required extensive assistance with one staff physical assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and personal hygiene. Resident #45 was not steady and only able to stabilize with staff assistance. Resident #45 had impairments to both sides to upper and lower extremities and used a wheelchair. The resident was always incontinent of bowel and bladder and had no falls or skin concerns recorded. Resident #45 received no anticoagulants (blood thinners). An interview was conducted with NA #3 via phone on 07/18/19 at 6:00 AM. NA #3 reported he worked the night of 07/10/19 going into 07/11/19. NA #3 reported Resident #45 was on his assignment and when he went to give her a bed bath and was undressing her, he noticed bruising on the right arm from the upper forearm area to the shoulder. NA #3 described the bruise as black and blue and purple and it covered the upper arm. NA #3 stated he told Nurse #1, and she told him that she would tell Nurse #4 because Nurse #1 was usually on the 500/600 hall. NA #3 stated Nurse #1 assessed the bruise. NA #3 stated he finished giving Resident #45 her bath and kept her in bed. NA #3 stated the resident did not show any signs of pain like grimacing or moaning. NA #3 stated he left the resident in bed so the day nurse (Nurse #4) could look at her. NA #3 stated the resident did not try to get out of bed. She was cooperative with care and had no falls. He stated he did not know how the resident got the bruise and he was not aware of the bruise prior to starting his shift. He stated whenever he saw a change in condition be it skin, mental status, pressure ulcer, an abnormal vital sign or injury of unknown origin, the facility protocol was	F 609	to Assessment and Notification for Acute Changes with emphasis on reporting acute change immediately to the physician, Administrator, resident representative, and DON to include but not limited to bruises or injuries of unknown origin. In-service will be completed by 8/25/19. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Assessment and Notification for Acute Changes. 10% audit of all residents progress notes and incident reports will be reviewed by the ADON, Nurse Supervisor, QA Nurse and/or Clinic Coordinators weekly x 8 weeks then monthly x 1 month utilizing the Incident Audit Tool. This audit is to ensure all injuries to include bruises, were reported timely to the Director of Nursing, Administrator, resident representative, and physician and that all injuries of unknown origin are reported in accordance with State Law. The ADON, Nurse Supervisor and/or Clinic Coordinators will provide notification and reeducate the nurse for any identified areas of concerns during the audits. The Administrator will review and initial the Incident Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Incident Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Incident Audit Tool to determine trends and/or issues that may	

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F 609	Continued From page 28 to notify the nurse. An interview was conducted with Nurse #1 on 07/17/19 at 7:15 AM. Nurse #1 stated on 07/11/19, NA #3 reported to her there was a bruise on Resident #45. Nurse #1 stated she assessed the bruise and noted it was on her right upper forearm and it was yellowish in color and about the size of her hand. Nurse #1 stated she moved the shoulder and arm around and the resident showed no signs or symptoms of pain. Nurse #1 stated she spoke with Nurse #4 on the day shift the morning of 07/11/19 because the bruise looked old to Nurse #1. Nurse #1 stated Nurse #4 stated she had no prior knowledge about a bruise on Resident #45. Nurse #1 reported that she was not told in report on the start of her shift on 07/10/19 going into 07/11/19 that Resident #45 had a bruise. Nurse #1 stated after she assessed the bruise, she did not do anything except report it to the oncoming nurse (Nurse #4). An interview was conducted with Nurse #4 on 07/19/19 at 11:55 AM. Nurse #4 reported she recalled Nurse #1 reporting to her on the morning of 07/11/19 Resident #45 had a bruise. Nurse #4 stated she went and assessed the bruise and it was on her upper forearm and it was small and purple. Nurse #4 stated it was not yellow or green to indicate it looked old. Nurse #4 reported she looked at the bruise again later on her shift and the resident had no complaints of pain. Nurse #4 stated she did not report or document on it because it was so small. Nurse #4 stated she received training on abuse and the types of abuse including injury of unknown origin. Nurse #4 stated there was a policy in place for abuse and neglect which included injury of unknown	F 609	need further interventions put into place and to determine the need for further frequency of monitoring.	

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origin, and if staff identified an injury of unknown origin, they were to notify their supervisor or the Director of Nursing (DON) immediately, complete an incident report, and notify the physician and the Responsible Party (RP).

An interview was conducted with NA #2 on 07/17/19 at 7:00 AM. NA #2 reported the early morning (night shift) staff was responsible for getting Resident #45 up and ready. NA #2 stated she worked the night shift on 07/12/19 and when she removed Resident #45 ' s robe, she noticed a bruise that was black and blue on the right upper forearm going up to her shoulder. NA #2 stated she did not see any open areas and the resident had no signs of pain. NA #2 stated she showed the bruise to NA #1 and she instructed her to report it to the nurse. NA #2 stated she covered the resident up and called Nurse #1 and stated she needed to come and see Resident #45. NA #2 reported Nurse #1 asked her if it was about the bruise and NA #2 said "yes." NA #2 stated Nurse #1 stated she was already aware of it because NA #3 had already informed her from a previous night. NA #2 reported that no staff member had reported to her anything about a bruise on Resident #45. NA #2 stated she proceeded to get Resident #45 up and get her ready and put her in the chair. She stated the resident did not express any pain. She did not grimace or flinch.

An interview was conducted with Nurse #1 on 07/17/19 at 7:15 AM Nurse #1 stated when she came in for her shift on 07/12/19 she palpated the bruise and performed range of motion and the resident had no complaints of pain or any signs or symptoms of pain. Nurse #1 stated there was no change in the bruise on 07/12/19. Nurse #1

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stated there was a policy in place for abuse and neglect which included injury of unknown origin, and if staff identified an injury of unknown origin, they were to notify the supervisor or Director of Nursing (DON) immediately, complete an incident report and an incident note, and notify the on call physician and the Responsible Party (RP). Nurse #1 stated she did not do anything because it looked "old." Nurse #1 stated the bruise was faded and had yellow edges and she did not know how the resident got the bruise.

An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 stated she worked from 7:00 PM - 7:00 AM on both 07/12/19 and 07/13/19 and no staff member reported to her a bruise on Resident #45.

An interview with the night shift charge nurse (NSCN) was conducted via phone on 07/20/19 at 6:45 AM. She stated on Sunday morning on 07/14 during the night shift hours, she was made aware of Resident #45 by NA #21 who stated the resident had a bruise on her arm and NA #2, who was nearby, stated she told the nurses a few days ago. The NSCN stated once she learned of it, she was told it had been reported to other nurses so she thought the bruise was addressed. NSCN stated NA #21 told her it was yellowed.

An interview was conducted with Nurse #2 on 07/18/19 at 11:59 AM. Nurse #2 reported on 07/14/19 at 4:00 PM she was taking care of another resident when NA #1 came up to her and asked her if she had seen Resident #45's arm. Nurse #2 stated she said "no." Nurse #2 reported NA #1 stated it looked a lot worse than the other day and she would have thought the nurse would have heard about the bruise in report. Nurse #2

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stated she went to the resident's room and removed her shirt and she had a huge bruise on her right arm. Nurse #2 reported she left immediately and told the Day Supervisor (Day S/V) at the nurse ' s station. Nurse #2 stated the Day S/V was on the phone with the Nurse Practioner (NP) at this time so she told her to tell the NP about the bruise and that she needed an order for an x-ray. Nurse #2 stated she obtained the order to get the x-ray and the Day S/V notified the family. Nurse #2 stated she was resting in bed and had no signs or symptoms of pain. Nurse #2 stated NA #1 reported she saw the bruise on Resident #45's arm a few days ago and it looked worse and that it was not swollen like it was today (07/14/19). Nurse #2 reported there was swelling and the bruise went from her forearm up to shoulder and was dark purple and green with yellowing edges and a lump in the upper forearm. Nurse #2 stated the resident did not appear to be in pain when she assessed the bruise. Nurse #2 reported when she saw it a couple of days ago it was just a small bruise and she did not think much of it. Nurse #2 reported no staff member had made her aware that the bruise had been there since 07/11/19.

An interview was conducted with Nurse #3 via phone on 07/18/19 at 6:00 AM. Nurse #3 reported on 07/14/19, Sunday evening, Nurse #2 reported off to her and told her Resident #45 had a bruise on her right arm. Nurse #3 stated Nurse #2 informed her the x-ray technician would be coming at 8:00 PM and to wait for the results. Nurse #3 reported that she was not aware of the bruise on Resident #45 until Sunday, 07/14/19. Nurse #3 stated no staff member reported to her regarding a bruise or injury of unknown origin. Nurse #3 stated she reported the result to the

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NSCN and thought she was going to call the DON and the physician since she was the Charge Nurse on 07/14/19 going into 07/15/19.

An interview with the night shift charge nurse (NSCN) was conducted via phone on 07/20/19 at 6:45 AM. The NSCN reported when she came back to work that evening on 07/14/19, the Dayshift Supervisor (Day S/V) had told her in the pre shift meeting that she looked into the injury of unknown origin and there was no documentation and found that nothing had been done about the bruise. The NCSN stated the Day S/V reported the Nurse Practioner (NP) was notified and an x-ray was ordered on 07/14/19. The NSCN stated she reported the x-ray result to the DON early in the morning on 07/15/19. The NSCN reported if there was an injury of unknown origin, the policy was to notify the physician right away, do an incident report, document, and call the family. She stated she received training regarding abuse, neglect and reporting of abuse, neglect, and injury of unknown origin. The NSCN stated she thought the bruise was already addressed since nurses were made aware a few days ago.

A review of an x-ray of the right arm for Resident #45 taken on 07/14/19 and revealed Resident #45 had an acute fracture to the humeral head and neck with impaction.

An interview was conducted with the facility physician on 07/18/19 at 4:15 PM. The physician stated when he came into the facility the morning of 07/15/19 and saw the x-ray result for Resident #45, he asked why the resident was still here and to get her to the Emergency Room (ER) now. The physician stated it was unknown what had

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F 609	Continued From page 33 happened and when the bruising had actually occurred, but the nurse who first identified the bruising on 07/11/19 should have notified him and he would have had her sent to the ER if he was the physician on call. The physician stated he did not believe the fracture could worsen from 07/14/19 (when the x-ray showed the fracture) until 07/15/19 (when the resident was sent to the ER). The physician stated, however, no one actually knows when she fractured it or how. An interview was conducted with the DON on 07/20/19 at 4:10 PM. The DON reported an investigation for injury of unknown origin was started on 07/15/19. The DON reported her expectation of the nurses would have been once they were made aware by the NAs of the bruise on Resident #45, they should have notified the physician, the RP, and the DON. The DON stated she would have expected the nursing staff to complete an assessment, document the assessment, and complete an incident report so an investigation could have been initiated on 07/11/19 when they bruise was first noticed to determine the injury of unknown origin.	F 609		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess resident cognition and/or resident mood in quarterly minimum data set	F 638	On 8/2/19, the Social worker completed a BIMs and mood interview for resident #16 and care plan updated as indicated.	8/25/19

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F 638	Continued From page 34 (MDS) assessments for 4 of 33 residents (Resident #16, #23, #33, and #45) whose minimum data set (MDS) assessments were reviewed. Findings included: 1. Record review revealed Resident #16 was admitted to the facility on 02/08/18. The resident's diagnoses included hypertension and atrial fibrillation. Review of Resident #16's 04/10/19 quarterly minimum data set (MDS) assessment revealed his cognition had not been assessed in section C, and his mood had not been assessed in section D. For C0100 "Should a brief interview for mental status be conducted?" the response of "not assessed" was documented. For C0600 "Should the staff assessment for mental status be conducted?" the response of "not assessed" was documented. For D0100 "Should resident mood interview be conducted?" the response of "not assessed" was documented. For D0500 "Staff Assessment of Resident Mood" the response of "not assessed" was documented. During a telephone interview with the MDS Nurse on 07/20/19 at 10:04 AM she stated it was the responsibility of the Social Workers (SW) to complete Sections C and D on the MDS. The MDS Nurse indicated that for these sections the SW should either interview the resident or assess the resident themselves in order to provide the responses. The MDS Nurse stated that documenting "not assessed" to all the prompts in sections C and D was not acceptable. During an interview with SW #1 on 07/20/19 at 10:27 AM he stated Resident #16 was alert and oriented and should have been interviewed in	F 638	Resident # 23, resident # 33 and resident # 45 no longer reside in the facility. On 7/24/19, 100% audit of the most recent MDS assessment section C and section D for all residents to include resident #16 was initiated by the Staff Facilitator to ensure all MDS□s assessments were completed accurately for cognition and mood status. The Social Worker will complete a BIMs and mood interview for any identified areas of concern during the audit with oversight by the Staff Facilitator. The audit will be completed by 8/25/19. On 7/25/19, the Facility Consultant completed a 100% in-service with the MDS Coordinator, MDS nurse and Social Workers in regards to MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator, MDS nurse or Social Worker will be in-serviced by the Staff Facilitator during orientation in regards to MDS Assessments and Coding. 10% audit of resident□s most recent MDS assessments, to include resident #16 will be completed by the Receptionist utilizing the MDS Accuracy Tool. This audit will be completed weekly x 8 weeks then monthly x 1 month to ensure accurate and complete coding of the MDS assessment to include section C and D. The Assistant Director of Nursing (DON) will address all areas of concern during the audit to	

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F 638	Continued From page 35 order to complete sections C and D of his MDS assessments. He reported he did go visit Resident #16 once and he was asleep, and he did not want to wake him. The SW explained he must have forgotten to re-approach the resident at later times in order to obtain an interview. According to SW #1, if he was unable to obtain an interview with the resident after multiple attempts he was allowed to assess the resident's cognition and mood himself. During an interview with the Director of Nursing (DON) on 07/20/19 at 12:02 PM she stated that the MDS assessments should be complete, accurate, and signed and transmitted on time. During a follow-up interview with the DON on 07/20/19 at 12:44 PM she stated since SW #1 and SW #2 were not collecting their data in a timely manner the MDS nurses were having to document "not assessed" in sections C and D of the MDS assessments in order to complete and submit them on time. 2. Resident #23 was admitted to the facility on 01/07/19 and discharged to the hospital on 07/09/19. Diagnoses included, in part, Parkinson's disease and dementia. A review of the Minimum Data Set (MDS) quarterly assessment dated 04/14/19 revealed Section D for the mood assessment for Resident #23 was marked as "not assessed". In a telephone interview on 07/20/19 at 10:04 AM, the MDS Nurse stated it was the responsibility of the SW to complete Sections C and D on the MDS. The MDS Nurse indicated for these	F 638	include retraining of the MDS nurse and/or Social Worker and completing necessary assessment of the resident. The Administrator will review and initial the MDS Accuracy Tool weekly x 8 weeks and then monthly x 1 month to ensure any areas of concerns were addressed. The Administrator will present the findings of the MDS Accuracy Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the MDS Accuracy Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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sections, the SW should either interview the resident or assess the resident themselves in order to provide the responses. The MDS Nurse stated that documenting "not assessed" to all the prompts in sections C and D was not acceptable and was incorrect.

An interview was conducted with the Director of Nursing (DON) on 07/20/19 at 12:02 PM. The DON stated the MDS assessments should be complete, accurate, and signed and transmitted on time.

An interview with the DON on 07/20/19 at 12:44 PM revealed since the assessment was not completed on time by the Social Worker (SW) #2, the MDS nurse put "not assessed" in Section D in order to complete and submit the assessment.

An interview with SW #2 on 07/20/19 at 12:45 PM revealed she did not know why the assessment for moods in Section D was not completed in the time frame it was supposed to be completed for Resident #23. SW #2 stated she was responsible for completing Section D and she had seven days to complete the assessment.

3. Resident #45 was admitted on 03/01/10. Diagnoses included, in part, cardiovascular disease, a fib, and Alzheimer's disease.

A review of the Minimum Data Set (MDS) quarterly assessment dated 05/03/19 revealed Section C for the cognition assessment for Resident #45 was marked as "not assessed".

In a telephone interview on 07/20/19 at 10:04 AM, the MDS Nurse stated it was the responsibility of the SW to complete Sections C and D on the

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F 638	Continued From page 37	F 638		

MDS. The MDS Nurse indicated, for these sections, the SW should either interview the resident or assess the resident themselves in order to provide the responses. The MDS Nurse stated documenting "not assessed" to all the prompts in sections C and D was not acceptable and was incorrect.

An interview was conducted with the DON on 07/20/19 at 12:02 PM. The DON stated the MDS assessments should be complete, accurate, and signed and transmitted on time.

An interview with the Director of Nursing (DON) on 07/20/19 at 12:44 PM revealed since the assessment was not completed on time by the Social Worker (SW) #2, the MDS nurse put "not assessed" in Section C in order to complete and submit the assessment.

An interview with SW #2 on 07/20/19 at 12:45 PM revealed she did not know why the assessment for cognition in Section C was not completed in the time frame it was supposed to be completed for Resident #45. SW #2 stated she was responsible for completing Section C and she had seven days to complete the assessment.

4. Resident #33 was admitted to the facility on 04/15/16 and had diagnoses of Parkinson's disease, Alzheimer's disease, and anxiety disorder.

Review of the quarterly Minimum Data Set (MDS) dated 05/01/19 revealed that Section C- Cognitive Patterns had not been assessed. The question, "Should brief interview for Mental Status be conducted," had a check mark in the yes column

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F 638	Continued From page 38	F 638		

but the interview was marked as "not assessed". The question, "Should staff assessment for Mental Status be conducted," also had a check mark in the yes column but the interview was marked as "not assessed".

Further Review of the quarterly MDS dated 05/01/19 revealed that Section D-Mood asked the question, "Should Resident Mood interview be conducted." There was a check mark in the yes column, but the interview was marked as "not assessed". The staff assessment of Resident Mood was also marked as "not assessed".

In a telephone interview on 07/20/19 at 10:04 AM the MDS Nurse stated it was the responsibility of the Social Worker (SW) to complete Sections C and D on the MDS. The MDS Nurse indicated that for these sections the SW should either interview the resident or assess the resident themselves in order to provide the responses. The MDS Nurse stated that documenting "not assessed" to all the prompts in sections C and D was not acceptable and was incorrect.

In an interview on 07/20/19 at 10:54 AM SW #1 stated that Resident #33 was usually able to answer the questions in sections C and D but that when he attempted to perform the interview Resident #33 seemed confused. He indicated that he should have spoken to staff and completed the staff assessment for Mental Status and the Staff Assessment of Resident Mood himself.

In an interview on 07/20/19 at 12:02 PM the Director of Nursing (DON) stated that the MDS assessments should be complete, accurate, and signed and transmitted on time.

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F 638	Continued From page 39 In a follow-up interview on 07/20/19 at 12:44 PM the DON stated since SW #1 and SW #2 were not collecting their data in a timely manner the MDS nurses were having to document "not assessed" in sections C and D of the MDS assessments in order to complete and submit them on time.	F 638		
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 observation, record review and staff and resident interviews, the facility failed to provide perineal care or toe nail care for 2 of 2 dependent residents reviewed for activities of daily living (Residents #44 and #104). Findings included: 1. Resident #44 was admitted to the facility on 01/24/18 and had diagnoses of trigeminal neuralgia (chronic facial pain), muscle weakness and anxiety disorder. The resident's quarterly Minimum Data Set (MDS) dated 05/03/19 revealed Resident #44 was severely cognitively impaired and was dependent on one staff member for toilet use and hygiene. Resident #44 was always incontinent of bowel and bladder. Resident #44's Care Plan initiated on 05/16/19	F 677	On 7/17/19, resident # 44 was provided perineal care by the treatment nurse with oversight from the Minimum Data Set Nurse (MDS). On 7/17/19, resident #104 was provided nail care by the Quality Assurance Nurse (QA). On 7/20/19 100% audit of nail care (fingernails and toenails) for all residents to include resident #104 was completed by the Director of Nursing (DON), the Clinical Coordinator, Staff Facilitator, QA nurse and Nurse Supervisor to ensure all residents were provided nail care per resident preference. The hall nurse, treatment nurse, and clinic coordinators provided nail care for all identified concerns during the audit. On 8/2/19, The QA nurse initiated a 100% return demonstration on Perineal Care with all nurses to include wound nurse # 1 and all nursing assistants. This was to	8/25/19

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F 677	Continued From page 40 revealed a focus of: Urinary and bowel incontinence: At risk for complications. Interventions included: to observe for signs and symptoms of urinary tract infection (UTI) and to provide peri-care after each incontinence episode. In an observation on 07/17/19 at 5:08 PM Wound Nurse #1 provided incontinent care for Resident #44 who had had a bowel movement. After positioning Resident #44 onto her side, wipes were used to clean the buttocks in a front to back motion. The soiled brief was removed, and a new brief was placed. After positioning Resident #44 to her back, the clean brief was fastened closed. When asked, Wound Nurse #1 stated she had completed incontinent care for Resident #44. When asked about peri-care Wound Nurse #1 unfastened Resident #44's brief and used a wipe to cleanse the peri-area in a front to back motion. She did not spread the labia to check for stool. When asked about cleaning inside the labia, Wound Nurse #1 spread Resident #44's labia and cleansed the area using a front to back motion. Brown stool was removed from the area and was visible on the cleansing wipe. In an interview on 07/17/19 at approximately 5:25 PM Wound Nurse #1 stated that when incontinence care for a female resident who had a bowel movement was performed the peri-area also needed to be cleansed, not just the buttocks. She indicated that the labia needed to be spread to make sure stool was not present because if not removed, the stool could cause a UTI. In an interview on 07/20/19 at 3:42 PM the Director of Nursing (DON) stated that when incontinence care was performed the buttocks	F 677	ensure staff (1) clean the entire perineal area to include opening the labia for female residents and (2) clean the front and back of the perineal area for all incontinent episodes to include feces. Return demonstrations will be completed by 8/25/19. 100% in-service was initiated by the Staff Facilitator on 8/7/19 with all nurses to include wound nurse # 1, nurse #15 and all nursing assistants in regards to: (1) Nail Care with emphasis on providing toenail care and (2) Perineal Care with emphasis on opening the labia for female residents. In-services will be completed by 8/25/19. All newly hired nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation in regards to Nail Care and Perineal Care with return demonstration. 10% observation of resident care to include toenail care and perineal care for all residents to include resident # 104 and resident #44 will be completed by the Clinical Coordinator, Staff Facilitator, QA nurse and Nurse Supervisor weekly x 8 weeks then monthly x 1 month utilizing a Resident Care Audit Tool . This audit is to ensue residents were provided nail care per resident preference and perineal care to include staff cleaning the entire perineal area including opening the labia for female residents and cleaning the front and back of the resident for all incontinent episodes. Any areas of identified concern will be addressed by the Clinical Coordinator, Staff Facilitator, QA nurse and Nurse Supervisor to include providing nail care, and perineal care and/or	

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F 677	Continued From page 41	F 677		

and peri-area should both be cleansed. She indicated that for a female resident who had a bowel movement, the peri-area needed to be cleansed and the labia spread to make sure no stool was left in that area. The DON stated that if stool was not cleansed from the labia it had the potential of causing a UTI in the resident.

2. Resident #104 was admitted to the facility on 01/11/19 with diagnoses that included respiratory failure with hypercapnia, malignant neoplasm (tumor) of lung/bronchus, chronic obstructive pulmonary disease (COPD), heart failure, atrial fibrillation, vertigo (dizziness), and lack of coordination.

A quarterly Minimum Data Set (MDS) assessment dated 06/17/19 documented that Resident #104 had intact cognition, used a wheel chair or walker for mobility and required supervision for toilet use and personal hygiene.

The care plan for Resident #104 dated 07/15/19 revealed he required assistance with activities of daily living/personal care due to poor endurance and decreased mobility related to COPD, respiratory failure, lung cancer and congestive heart failure. Activities documented as requiring a one person assist included bathing, personal hygiene/grooming, dressing, eating, transfers and toileting.

On 7/17/19 at 8:45 AM an observation was made of the resident's toenails on his right foot. The second toe had a nail that was growing to the left and indenting into the side of the neighboring toe, (the great toe). In an interview with Nurse #15, who was present and looking at the toenail, she commented the nurse aides were supposed to

additional staff training. The DON will review and initial the Resident Care Audit Tools weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed.
The Administrator will present the findings of the Resident Care Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Resident Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 677	Continued From page 42 provide nail care unless a resident was diabetic. She stated the nurses themselves did not have time to provide nail care. In an interview with Resident #104 at the same time, he commented he had asked nursing staff for the toenail to be trimmed and no one would cut it. He said he was not able to trim his own toenails and that the nail was poking into his big toe which was uncomfortable. In an interview with the facility Nurse Consultant on 07/19/19 at 9:00 AM she stated the toenail on Resident #104's right foot should have been trimmed and she would have staff trim it immediately. In an interview with the Director of Nursing (DON) on 07/18/19 at 11:10 AM she revealed that nail care was to be done every shower day for each resident. She commented nurse aides could not perform the task for residents who were diabetic, in which case the aides were to notify the nurse to perform the task. If when a nurse assessed a nail and found it to be too thick to cut then a referral was to be made to the podiatrist who visited monthly. She stated if a nail was impeding another neighboring toe the nurse was expected to put something between the toes to protect them and consult the wound care team to assess the skin integrity of the areas affected. She stated the nurses were to make time to trim nails for residents.	F 677		
F 684 SS=D	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	F 684		8/25/19

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F 684	Continued From page 43 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure 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 physician interview, staff interview, and record review the facility failed to assess and administer medication for nausea and vomiting for 1 of 1 sampled residents (Resident #190) following an episode of vomiting. Resident #190 experienced a second episode of vomiting two hours and fifteen minutes later on the same shift. Findings included: Record review revealed Resident #190 was admitted to the facility on 10/12/18. His documented diagnoses included history of cerebrovascular accident (CVA) with hemiplegia, congestive heart failure, hypertension, diabetes, epilepsy, gastroesophageal reflux disease, and aphasia. Resident #190's 01/22/19 quarterly minimum data set documented he had short and long term memory impairment, his decision making skills were extremely impaired, he exhibited no behaviors including resistance to care, and he required extensive assistance from staff to being dependent on staff for his activities of daily living (except he only required supervision when eating, after staff had set up his meal tray). Review of Resident #190's medical record revealed the resident had standing orders which included Phenergan suppository 25 milligrams (mg) every (Q) six hours as needed (prn) x 3	F 684	Resident # 190 no longer resides in the facility. On 8/7/19, 100% audit of all resident progress notes was initiated for the past 7 days by the Assistant Director of Nursing (ADON). This audit is to ensure that all residents with acute changes to include vomiting was assessed by nursing staff with a complete set of vitals, initiation of interventions as indicated to include as needed (prn) medication administration per physician□s order to prevent reoccurrence, and notification of the physician and resident/resident representative. The Clinic Coordinators, Nurse Supervisor, QA Nurse, and Staff Facilitator will address all areas of concern identified during the audit. The audit will be completed by 8/25/19. On 7/17/19 a 100% in-service was initiated by the Staff Facilitator with all nurses in regards to Assessment and Notification for Acute Changes with emphasis on (1) assessment of the resident to include vital signs (2) initiation of interventions to include administration of prn medications per physician□s order to prevent reoccurrence (3) notification of the physician and resident/resident representative. The in-service will be completed by 8/25/19. All newly hired	

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F 684	Continued From page 44 doses, may give Phenergan 25 mg IM (intramuscular) if unable to give suppository for nausea/vomiting. The physician was to be called if symptoms persisted for more than 24 hours. Review of Resident #190's February 2019 medication administration record (MAR) revealed he received no anti-nausea medications on the night of 02/19/19 or the morning of 02/20/19. In a 02/20/19 6:54 AM nurse's note Nurse #1 documented, "Resident (#190) vomited times two this shift. Moderate amount of liquid vomitus. Sitting up in bed c/o (complaining of) stomach ache. VSS (vital signs): 97.0 (temperature)-72 (pulse)-22 (respirations per minute)-138/68 (blood pressure). (Nursing Assistant #2) making rounds found resident had vomited again..." Further review of Resident #190's medical record revealed there was no assessment of the resident's condition following the resident's first episode of vomiting during the early morning hours of 02/20/19. During an interview with Nurse #1 on 07/18/19 at 6:52 PM she stated she thought the vital signs she included in her nurse's note were provided to her by Nursing Assistant (NA) #2, thinking maybe she provided them to her on a piece of paper and she transposed them into her nurse's note. She reported she had no idea when NA #2 had taken the vital signs. She commented she ending up writing a nurse's note capturing Resident #190's change in condition because she was the only facility nurse in the building at the time the resident experienced the two episodes of vomiting. During a telephone interview with NA #2 on	F 684	nurses will be in-serviced by the Staff Facilitator during orientation in regards to Assessment and Notification for Acute Changes. 10% review of all residents□ progress notes will be completed by the Clinic Coordinators, Nurse Supervisor, QA Nurse and Staff Facilitator, and ADON weekly x 8 weeks then monthly x 1 month utilizing the Acute Change Audit Tool. This audit is to ensure all residents with acute change to include vomiting was assessed by nursing staff with a complete set of vitals, initiation of interventions as indicated to include as needed (prn) medication administration per physician□s order to prevent reoccurrence, and notification of the physician and resident/resident representative. The DON will review and initial the Acute Change Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Acute Change Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Acute Change Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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7/19/19 at 7:33 AM she stated she did not recall taking any vital signs for Resident #190 on third shift starting on the night of 02/19/19.

In a written statement on 02/20/19 NA #2 documented at around 12:30 AM on 02/19/19 when she went into Resident #190's room during her hall rounds she found the resident had thrown up all over himself and the floor. She notified Nurse #1, and documented, "The resident said his tummy (hurt)." According to NA #2, she cleaned Resident #190 up and "peeked" in on him roughly every half hour, "he was sitting upright holding the basin." The NA documented at around 2:45 AM on 02/19/19 she found that the resident had thrown up again.

During a telephone interview with NA #2 on 07/17/19 at 4:08 PM she stated Resident #190 usually slept well through the night, and if he was not asleep he was very docile in bed. She reported she did not remember much about the resident's first vomiting episode on 02/20/19, but she notified Nurse #7 who checked on the resident. She commented she cleaned up the vomitus on the resident, on the floor, and in his bed, and thought she checked on the resident, who was sitting up in bed, one other time before finding that he had vomited again. She remarked that this time the vomit resembled dark coffee grounds. According to NA #2, she notified Medication Aide #1 who went to check on the resident.

During an interview with Nurse #1 on 07/17/19 at 6:35 PM she stated on the morning of 02/20/19 she was working on another hall from the one where Resident #190 resided. She reported Nurse #7 was Resident #190's hall nurse. She

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commented she was notified of the resident's second episode of vomiting, and when she entered the resident's room she found Resident #190 covered with a large amount of coffee ground emesis. She remarked the resident was reclined in the bed with the head of the bed raised to at least a 45 degree angle. She stated it looked like someone had positioned the resident so that he would vomit into the floor rather than in his bed. According to Nurse #1, she reported she was not assigned to care for Resident #190, but when she had a resident who vomited with complaints of a stomach ache she obtained a complete set of vital signs, turned the resident on their side, made sure the resident had a clear airway, called the on-call physician, and stayed with the resident until her call was returned by a physician. She stated she would document this information in a nurse's note. Nurse #1 commented the facility had standing orders for nausea and vomiting, had an e-interact system that should be utilized when there was a significant change in condition, and had protocols about what to do for different changes in condition that could be accessed electronically and were in notebooks at the nursing stations.

During a telephone interview with Nurse #7 on 07/18/19 at 12:27 PM, she denied being Resident #190's hall nurse from 7:00 PM on 02/19/19 through 7:00 AM on 02/20/19. She reported she was not responsible for assessing the resident since he was not on her assignment. However, she commented she was trained after an episode involving a lot of vomitus to obtain vital signs, check bowel sounds, check the abdomen, administer standing order for nausea medications, and call the doctor if it looked like the medications were not effective.

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During an interview with the facility's Director of Nursing (DON) on 07/18/19 at 3:38 PM she stated according to staffing assignment sheets Nurse #7 was the hall nurse assigned to care for Resident #190 from 7:00 PM - 7:00 AM on 02/19/19 going into the morning of 02/20/19. She reported Nurse #1 and Medication Aide #1 were assigned to care for residents on another hall beside the one where Resident #190 resided. She explained Nurse #1 and Medication Aide #1 became involved with Resident #190 because Nurse #7 was overwhelmed with nursing issues, with Medication Aide #1 helping to administer medications on the hall where Resident #190 resided.

During a telephone interview with Medication Aide #1 on 07/17/19 at 5:10 PM she stated she found Resident #190 covered in a large amount of dark coffee ground emesis (vomit) when NA #2 called her to the resident's room after his second episode of vomiting. She reported episodes of nausea/vomiting were not normal for this resident. She commented Resident #190 had a standing order for medications to address nausea and vomiting, but she would not administer them until a nurse assessed the resident. Medication Aide #1 stated she was not aware that Resident #190 had a previous episode of vomiting until other nurses joined her in the resident's room.

During an interview with the DON on 07/18/19 at 9:38 AM she stated an e-interact change of condition was not completed on Resident #190, probably because of the hectic nature of events, but that was not an acceptable excuse, and Nurse #7 should have assessed Resident #190 after his first episode of vomiting on 02/20/19 and

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should have completed the form even if she went back later and did so after the events.

During an interview with the DON on 07/18/19 at 3:38 PM she stated after Resident #190 had the first episode of vomiting and was complaining of a sore stomach the nurse should have checked bowel sounds, performed an abdominal assessment, administered the nausea medication, and documented if the medication was effective which would have determined if physician contact was warranted. She reported there were protocols in the medical record system which the nurses could access that walked them through what to do in response to significant changes. She provided the protocol for GI distress.

During an interview with Resident #190's primary physician on 07/18/19 at 3:48 PM he stated when residents experienced an episode of vomiting, the nurse should obtain vital signs, check bowel sounds and assess the abdomen, ascertain whether the resident was experiencing any other changes in condition, and determine if there were problems with any other body systems. He reported the nurse should use this assessment to determine whether the administration of anti-nausea medications was warranted. He commented if those medications were administered, the effectiveness would determine whether physician contact was necessary. He commented the facility should follow up on residents at least 1 - 2 hours after an episode of vomiting. According to the physician, it would have been beneficial to the facility and Resident #190 if they had conducted an assessment at least somewhat similar to what he described above after Resident #190's first episode of

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F 684	Continued From page 49 vomiting. He stated coffee ground emesis was an indication that there was digestive blood involved. He reported Resident #190 should have had the head of his bed raised after the first episode of vomiting.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews the facility failed to evaluate the effectiveness of the facility wound treatment protocol and seek further treatment after the deterioration of a pressure ulcer on the right gluteal fold from a stage II to an unstageable wound and failed to conduct a weekly wound assessment with measurements on an unstageable pressure ulcer to assess for deterioration for 1 of 7 sampled residents with pressure ulcers which resulted in a stage IV pressure ulcer with loss of muscle tissue, the development of a stage II pressure ulcer on the right buttock, and the development of a stage III	F 686	Resident #50 wounds to include the right gluteal fold was assessed with wound measurements by the on 7/18/19 medical record by the MDS nurse. Resident #50 was seen by the attending physician on 7/18/19 for deterioration of pressure ulcer and examined by the Wound Clinic physician on 7/25/19 for further evaluation and treatment of wounds. 100% audit of all current residents with wounds to include resident #50, wound documentation from 7/1/19 to 7/31/19 was initiated on 8/7/19 by the Assistant Director of Nursing (ADON). The purpose	8/25/19

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F 686	Continued From page 50 sacral ulcer. (Resident #50) Findings included: Resident #50 was admitted to the facility on 4/11/19 with active diagnoses in part to include; Diabetes, Anemia, and Traumatic Brain Injury, and Obesity. He did not receive palliative or comfort care measures. Review of the admission Minimum Data Set (MDS) dated 4/18/19 documented Resident #50 had severely impaired cognition. He was able to make his needs known. He required extensive two person assist with bed mobility and transfers. There were no pressure ulcers on admission. Review of the weekly skin assessment dated 5/31/19 documented a small area of abraded skin was noted on the left buttocks, apply barrier cream with brief changes. A QA (quality assessment) note dated 06/03/2019 documented; right gluteal fold open area, resident #50 gets up approximately 10:30 AM every day and goes back to bed between 7-8 PM. Resident had lift pad under him in the wheelchair. Resident was care planned to remove the lift pad from underneath him while he is sitting up in the wheelchair. Review of the weekly skin assessment dated 6/4/19 documented the right gluteal fold with 6.8 cm (centimeter) in length x 8.4 cm in width, stage II with yellow drainage, red base with defined edges. Cleanse with Calcium Alginate and cover with dry dressing, with preventative interventions to include; repositioning, foam mattress, and a foam cushion for wheelchair.	F 686	of the audit is to ensure documentation of weekly wound assessments have been completed to include accurate measurements of the wounds and documentation of physician and resident representative notification for any deterioration in wound. 100% of current residents with wounds to include resident #50, wounds were physically assessed with measurements obtained and documented in the electronic medical records by the Treatment Nurse with oversight of the Minimum Data Set Nurse (MDS) on 8/5/19-8/9/19. The purpose of the audit is to observe for any deterioration of wounds and evaluate the effectiveness of the current treatment plan. The physician will be notified for further treatment by the ADON, Clinic Coordinator, Treatment Nurse and/or QA nurse during the audits for any identified areas of concern. Audits will be completed by 8/25/19. An in-service was initiated on 8/7/19 by the Facility Consultant with the treatment nurses regarding Wound Care with an emphasis on: wound measurements, requirements for documentation of wounds, requirements for initial assessment and weekly assessments, staging, and physician/resident representative notification of new or worsening wound. The in-service will be completed by 8/25/19. All newly hired treatment nurses will be in serviced by the Staff Facilitator during orientation in regards to Wound Care. 10% of all residents with wounds to include resident # 50, wounds will be	

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F 686	Continued From page 51 A Dietician note dated 6/6/19 documented; a wound assessment indicated resident #50 had a stage II area to the right gluteal fold, his weight on 6/5/19 was 250.5 lbs. (pounds). Resident consumes 100% of meals per intake records and received a regular diet with double portions. Medications included; Vitamin C and Vitamin D. Interventions in place to aid in wound healing. A review of the electronic medical record dated June 2019, documented resident #50 received Zinc 220 milligrams for 14 days beginning 5/22/19, and Vitamin C daily beginning 5/22/19 to promote wound healing for 30 days. Review of the weekly skin assessment dated 6/11/19 documented right gluteal fold with 7.5 cm in length x 8.4 cm in width, stage II with moderate serous exudate (drainage), no tunneling, no undermining, no infection, apply Calcium Alginate and cover with dry dressing daily and weekly assessments. Review of the weekly skin assessment dated 6/18/19 documented; right gluteal fold with 9cm in length x 10.8 cm in width, unstageable, with no tunneling, undermining or odor, 90% eschar, to apply Calcium alginate dressing daily and weekly assessments. There was no skin assessment that included weekly wound measurements documented for the week of 6/24/19. Review of the skilled nursing notes from 6/24/19 through 7/1/19 revealed no documentation that a weekly wound measurement was conducted.	F 686	physically assessed and wound documentation reviewed in the electronic medical record by the Assistant Director of Nursing (ADON) weekly x 8 weeks then monthly x 1 month utilizing a Wound Care Audit Tool. This audit is to ensure that all resident□s wounds have been accurately assessed with an effective treatment plan, documentation of weekly wound assessment with measurements, and the physician and resident representative have been notified of new and/or worsening wounds. The treatment nurse will be retrained for all identified areas of concern by the ADON during the audit. The DON will review and initial the Wound Care Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The DON will present the findings of the Wound Care Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Wound Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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A nursing progress note dated 6/24/19 at 3:36 PM written by Nurse #1 documented; to cleanse the right inferior gluteal fold and upper thigh with NS (normal saline), apply Santyl (a debriding agent) and cover with dry dressing daily, every day shift. The resident refused to go back to bed after lunch. He remained up at this time. The hall nurse said she would do the treatment when he went to bed. Spoke to RP (responsible party) about resident #50's wound. He is non-compliant, he was asked to return to bed. He refused.

Review of the weekly skin assessment dated 7/2/19 documented the right gluteal fold with 7.5 cm x 11.4 cm, unstageable, with no tunneling, undermining or odor, 90% eschar. Cleanse with Santyl, cover with dressing.

A review of the facility wound protocol updated on 5/22/18 indicated for stage III ulcers, Santyl may be utilized if an area does not respond to other treatments.

A physician order dated 7/3/19 documented an order written for a referral to the wound clinic regarding the right gluteal fold pressure ulcer, to cleanse with Santyl, and cover with dressing.

A physician's order dated 7/8/19 documented an order for Flagyl 500mg (antibiotic) daily to right posterior thigh for wound odor.

Review of the weekly skin assessment dated 7/10/19 documented the right gluteal fold with 14 cm x 11.5 cm x 3.8 cm, unstageable, with no tunneling, undermining or odor, 90% eschar. Cleanse with Dakins wet to dry, and weekly assessments.

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A Dietary supplement review note dated 7/11/19 for Resident #50 documented; residents nutritional needs for weight maintenance, skin integrity, healing, and protein stores was calculated due to areas of breakdown. His intake of meals averaged 83%. His body weight was down 9lbs or 3.4% over one month and has fluctuated over two months with no significant change. Wounds are worse, continue to monitor.

A physician's order dated 7/12/19 documented an order for Juven Packet (nutritional powder to support wound healing) twice daily for 14 days, and Prostat liquid (protein liquid for wound healing) twice daily for 90 days, and Zinc (supplement) 220 milligrams for 14 days for wound healing.

A review of the weekly skin assessment dated 7/16/19 documented a newly identified stage III pressure ulcer to the sacrum which measured 5cm x 2.5 cm x 3 cm.

Review of the care plan revised on 7/17/19 documented, actual skin integrity impairment; pressure ulcers to sacrum, and right thigh. Goals included; will show positive healing of skin integrity and impairment as evidenced by smaller size, and resolution of eschar. Interventions included; ensure appropriate pressure relieving devices are in place during repositioning, nutritional supplements as ordered, observe for and monitor changes in skin integrity or skin impairment and notify physician as necessary, provide treatment as ordered, monitor for nonhealing or infection. Refer to wound clinic, turn and reposition patient frequently.

In an observation on 7/17/19 at 9:40 AM with the

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wound treatment nurse (Nurse #1), wound care was performed for Resident #50. Three areas, a right gluteal fold stage IV pressure ulcer, a stage II pressure ulcer on the left buttocks, and a stage III pressure ulcer on the sacrum was observed. Each of the three pressure wounds were cleansed with Dakin ' s solution and covered with a bandage. Resident #50 voiced no complaints of pain.

In an interview on 7/17/19 at 10:00 am with the wound treatment nurse (Nurse #1), she stated all wounds were assessed and measured weekly, and if the wounds worsened the facility physician or nurse practitioner would be notified. She stated Resident #50 had an appointment to be seen at the wound clinic the following week around July 25th. Nurse #1 stated the stage III pressure ulcer to the sacrum was just identified on 7/16/19, and when the wound was measured and identified as a stage III, she began the facility wound protocol which included a wound cleansing solution and covering with a dry dressing. Nurse #1 stated that resident #50 would stay up in his wheelchair by choice all day and the staff would have to make him go back to bed to relieve the pressure on the wounds. She stated he was able to turn and reposition himself while in the bed, he had a pressure reducing cushion in his wheelchair, and they no longer leave the lift pad underneath the resident when he is sitting in the wheelchair.

A phone interview was conducted on 7/17/19 at 12:30 PM with the wound clinic to confirm resident #50's appointment on July 25th. The clinic confirmed that it takes approximately two weeks to get appointments scheduled due to the volume of patients that come to the clinic.

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In a follow up interview on 7/17/19 at 12:40 PM with the wound treatment nurse (Nurse#1), she stated she didn't know there was no documentation to show that Resident #50's wounds were not measured for deterioration during the week of June 24, 2019. She stated she may have done the measurements but didn't document it, then stated she was not sure.

In an interview on 7/17/19 at 12:55 PM with the facility Nurse Practitioner, she stated that the treatment nurses handled the wound care and reported to her or the physician as needed. She indicated she had not assessed Resident #50's pressure wounds on that day and would follow up.

A follow up wound treatment observation was conducted on 7/18/19 at 10:05 AM with the wound treatment nurse (Nurse #1) and with the facility physician present. The wounds were measured, the right gluteal fold was 9 cm in length x 13 cm in width x 4 cm depth with loss of muscle tissue, a stage II left buttocks pressure wound measured 2.4 cm x 6.2 cm, with no depth, and the stage III sacrum measured 4.5 cm x 3cm x 4 cm. The physician acknowledged the wounds needed debridement which would be done during the upcoming wound clinic appointment.

An interview was conducted with the facility physician on 7/18/19 at 10:20 AM. He stated the wound treatment nurses were to follow the facility wound treatment protocol and notify him when the wounds worsened, or if wounds failed to respond to treatment, and he would change the treatment order or refer the resident to the wound clinic. He stated he trusted that the nurses in the facility were notifying him regarding worsening

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F 686	Continued From page 56 signs or symptoms of wounds. He acknowledged that the right gluteal wound had declined and stated a referral was made to send the resident to the wound clinic. He indicated that the resident was in the wheelchair during the day and was non-compliant with staying off the wound. In an interview on 7/20/19 at 1:12 PM with the second facility wound treatment nurse (Nurse #2) she confirmed that all wounds were to be assessed and measured weekly in order to notify the physician if the wounds had worsened. Nurse #2 stated they (Nurse #1 and Nurse #2) needed to be more proactive with wound care. In an interview conducted on 7/20/19 at 1:38 PM with the Director of Nursing (DON), she stated weekly weight and wound meetings were conducted every Friday which included the DON, Quality Improvement nurse, the wound nurse, the MDS nurse, and a member of the therapy department. She stated when the nurses notify the physician, they usually receive phone orders for treatments, or referrals for the wound clinic She stated the wound nurses are expected to monitor wounds through weekly wound assessments with measurements and are expected to notify the physician of new or worsening wounds.	F 686		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		8/25/19

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F 692	Continued From page 57 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff, hospice, and Nurse Practitioner interviews the facility failed to provide a protein supplement ordered by the physician for wound healing for 1 of 10 residents (Resident #44) reviewed for nutrition and hydration. Findings included: Resident #44 was admitted to the facility on 01/24/18 with diagnoses of Trigeminal neuralgia (chronic facial pain), Adult Failure to Thrive (AFTT) and protein-calorie malnutrition. Review of the Physician Telephone Orders dated 01/18/19 revealed an order for prostat (a protein supplement) 30 cc (cubic centimeters) bid po (twice each day by mouth). Review of the January 2019 paper Medication Administration Record (MAR) revealed the order for the prostat had been transcribed to the MAR. Review of the February 2019 paper MAR	F 692	On 7/18/19, Prostat orders for resident #44 were clarified and corrected in Electronic Medication Administration Record (EMAR) under the appropriate category by the Clinical Coordinator. On 8/2/19, an audit of all residents to include resident #44 supplement orders to include orders for Prostat was initiated by the Clinic Coordinator to ensure supplement orders were transcribed accurately and documented after providing supplement on the medication administration record (EMAR). The physician was notified and orders clarified by the Clinical Coordinator for all identified areas of concern. The audit was completed on 8/5/19. An in-service was initiated on 8/7/19 by the Staff Facilitator with all nurses in regards to Transcribing MD Orders and Documentation on the MAR to include dietary supplements and placing orders	

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F 692	Continued From page 58 revealed the order for the prostat had been transcribed to the MAR. Review of the March 2019 signed Physician Orders revealed a handwritten order for prostat 30 ml (millilters) bid po. Review of the March 2019 paper MAR revealed the order for the prostat had been transcribed to the MAR. The last recorded date of medications and supplements administered on the March 2019 paper MAR was 03/12/19. Review of the March 2019 electronic (e) MAR which began on 03/13/19 revealed no order for the prostat. Review of the April, May, June, and July 2019 eMAR revealed no orders for the prostat. Review of the quarterly Minimum Data Set (MDS) dated 05/03/19 revealed Resident #44 was severely cognitively impaired, did not reject care, and needed the extensive assistance of one person for eating. Resident #44 was under the care of Hospice. Resident #44 had one stage 2 unhealed pressure ulcer. Review of Resident #44's Care Plan revised on 05/16/19 revealed a focus of State of nourishment; Resident is at risk for further skin breakdown. Interventions included diet as ordered and protein supplementation. Review of the Physician Telephone Orders dated 06/07/19 revealed an order for the percentage of the prostat consumed by the resident to be documented on the MAR.	F 692	under the correct category in the EMAR. . In-service will be completed by 8/25/19. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Transcribing MD Orders and Documentation on the MAR. 10% of all residents to include resident #44 newly written physician□s orders for supplements will be compared to the MAR by the Clinic Coordinator weekly x 8 weeks then monthly x 1 month utilizing the Transcription/Documentation Audit Tool. This audit is to ensure that all orders to include supplements were transcribed accurately to the EMAR, placed under the correct category, and is being documented after the supplement is provided. The DON will review and initial the Transcription/Documentation Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The DON will present the findings of the Transcription/Documentation Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Transcription/Documentation Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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Review of the July 2019 active orders revealed under the category: Supplement an order for prostat 30cc po bid. The start date was listed as 02/15/19 and the order was revised on 06/08/19.

In an interview on 07/18/19 at 12:00 PM the Hospice Nurse stated that as a contracted employee she did not have access to the eMAR, so she did not realize Resident #44 was not getting the prostat bid as ordered. She indicated that although hospice did not expect Resident #44's wounds to heal completely, the added prostat would help to maintain the wounds so they would not worsen.

In an interview on 07/18/19 at 4:12 PM Nurse #12 stated that when it was time to administer a medication or a supplement to a resident it popped up on the eMAR. She reviewed the active orders and indicated that the prostat would not show up on the eMAR because it was listed under the supplement category which was incorrect. Nurse #12 stated that when the Night Shift Charge Nurse revised the prostat order on 06/08/19 to add the documentation of the percentage consumed, she did not revise the category, so neither order would show up on the eMAR. She stated that if the order did not show up on the eMAR she would not know she was supposed to administer the medication or supplement.

In an interview on 07/18/19 at 4:28 PM Unit Coordinator #2 stated that the prostat supplement was entered into the orders incorrectly on the eMAR when the facility changed over from paper to electronic charting in mid-March. She verified that since the order was entered under the wrong category it was not showing up in the eMAR and

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F 692	Continued From page 60	F 692		

the nurses did not know they should administer it.

In an interview on 07/19/19 at 11:31 AM the Registered Dietician (RD) stated Resident #44 was on Hospice. She indicated that the prostat had been ordered for wound healing. The RD stated she did not realize that the prostat had not been placed on the eMAR and that it was not being administered.

In a telephone interview on 07/19/19 at 3:15 PM the Night Shift Charge Nurse verified that she had revised the prostat order to show that the percentage consumed needed to be documented. She indicated that she was not aware that the prostat was listed under the wrong category and was not showing up to be administered on the eMAR. The Night Shift Charge Nurse indicated that she would usually check the eMAR after putting in orders to make sure they entered correctly but that she must have missed doing so this time.

In an interview on 07/19/19 at 4:00 PM Nurse Practitioner (NP) #1, who was part of Resident #44's physician group, stated that the group expected protein supplements to be provided to residents as ordered. She indicated that protein supplements were usually ordered for wound healing and were an important part of each resident's plan of care.

In an interview on 07/20/19 at 3:42 PM the Director of Nursing (DON) stated she expected orders to be transcribed correctly into the eMAR and for residents to receive the correct medications and supplements. She indicated that the nurse who was responsible for checking that the orders had been transferred correctly to the

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F 692	Continued From page 61 electronic record when the new electronic system was put in place no longer worked at the facility. The DON stated that it was important for Resident #44 to have received the protein supplement as ordered for wound healing.	F 692		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		8/25/19

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F 732	Continued From page 62 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the required nurse staffing information for one of six days of the survey. The findings included: On Saturday, 07/20/19 at 11:53 AM a facility tour revealed a nurse staff posting located on the wall by the facility's main entrance was dated Friday, 07/19/19. On 07/20/19 at 11:54 AM an interview was conducted with the facility nurse? consultant. She indicated that it was her expectation that the staff posting be current, posted daily, and that her expectation was not being met. On 07/20/19 at 11:55 AM an interview was conducted with the Director of Nursing (DON). She stated the facility employee who was responsible for posting the daily staffing sheet did not work on the weekends, and that no one posted the daily staffing sheet on 07/20/19 (a Saturday) and no one was responsible for posting the staffing information on the weekends. She said it was now her expectation, that weekend nurses would post the daily staffing, on weekends. On 07/20/19 at 11:56 AM and interview was conducted with the facility administrator. She	F 732	On 7/20/19, The Director of Nursing immediately posted the Daily Nursing Staff Sheet in the hallway near the lobby with complete staffing information and resident census. On 7/24/19, 100% audit of the Daily Staffing Sheets for the past 30 days was completed by Facility Consultant to ensure all sheets were completed accurately to include resident census and that the current day was posted per facility protocol. There were no additional concerns identified during the audit. On 7/25/19, the Staff Facilitator initiated an in-serviced with the Administrator, Director of Nursing (DON), Clinic Coordinators, Scheduler, Receptionist and Nurse Supervisor in regards to Posting of Daily Staffing Sheet with complete information to include the census at the beginning of the shift. In-service will be completed by 8/25/19. All newly hired Administrator, DON, Clinic Coordinators, Scheduler and Nurse Supervisors will be in-serviced by the Staff Facilitator during orientation in regards to Posting of Daily Staffing Sheet. The Clinic Coordinators will audit the Daily Staffing sheets to include weekends, weekly x 8 weeks and monthly x 1 month to ensure daily posting includes complete	

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F 732	Continued From page 63 stated that it was her expectation that the staff posting be current, posted daily, and that her expectation was not being met on the weekends.	F 732	information prior to the beginning of the shift utilizing the Daily Staffing Audit Tool. The Staff Facilitator and/or Clinic Coordinators will retrain staff for any identified areas of concern during the audit. The Administrator will review and initial the Daily Staffing Audit Tool weekly x eight weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will present the findings of the Daily Staffing Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Daily Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		8/25/19

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F 758	Continued From page 64 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to discontinue a PRN (as needed) psychotropic medication after fourteen days for 1 or 7 residents (Resident #116) reviewed for unnecessary medications.	F 758	On 8/2/19, the registered nurse obtained a clarification order from the physician regarding prn Ativan for resident # 116. A new order was written and transcribed to the Electronic Medical Record (EMAR).	

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F 758	Continued From page 65 The findings included: Resident #116 was admitted to the facility on 07/18/17 with diagnoses that included dementia with behavioral disturbance, anxiety, depression, restlessness and agitation. A significant change Minimum Data Set (MDS) assessment dated 07/04/19 revealed no behaviors or moods were displayed during the look back period. He required extensive assistance with activities of daily living with an impairment of both upper and lower extremities on one side. He was always incontinent of bowel and bladder and used a wheelchair for mobility. He received a scheduled antianxiety medication on two of the days. He was receiving Hospice services. The July 2019 physician orders reviewed on 07/17/19 revealed the following active order: Ativan 0.5 mg (milligram) by mouth every four hours as needed for anxiety and agitation (start date 06/28/19). He also had an order for scheduled Ativan 0.5 mg twice a day. Review of a Pharmacist Consultant Progress note written on 07/08/19 at 2:48 PM read: "R: RN - PRN Ativan stop date" indicating the pharmacist recommended obtaining a stop date for the prn Ativan order. The Physician Progress notes revealed no notes were documented between 06/28/19 and 07/17/19. There was no documentation in the medical record from the physician to address continuing the resident's prn Ativan order beyond 14 days.	F 758	On 7/25/19, the Pharmacy Consultant completed a 100% audit of PRN psychotropic medications. This audit was to ensure PRN psychotropic medications for all residents to include resident # 116 were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time in the medical record and indicated the specific duration. The Clinic Coordinator, Staff Facilitator, QA nurse and Nurse Supervisor will address all areas of concern identified during the audit to include notification of the attending physician or prescribing practitioner for further orders. On 8/7/19, the Staff Facilitator initiated a 100% in-service with all nurses in regards to PRN Psychoactive Medication Monitoring. Emphasis was placed on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for the extended time period in the medical record and indicates the specific duration. In-service will be completed by 8/25/19. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to PRN Psychoactive Medication Monitoring. 10% audit of all residents to include resident # 116 physician orders for PRN psychotropic medications will be reviewed by the Assistant Director of Nursing	

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F 758	Continued From page 66 An interview was conducted with the Director of Nursing (DON) on 07/18/19 at 11:10 AM. She explained that she tracked the PRN medications to ensure that none exceed the 14 days. She stated the pharmacy sent her a report each month of all pharmacy recommendations. She used that report to track the PRN psychotropic orders. She said she did not always get the report right away. She did not realize until just then that using the pharmacy report to monitor how long a prn psychotropic order had been in effect was not the best method because of the time lapse between the pharmacy review and the receipt of the electronic report. She stated she did not receive the July pharmacy report with recommendations until 07/12/19. She did receive a pharmacy recommendation to stop the prn Ativan order but because of the method she was using to monitor psychotropics the order was beyond 14 days. She concluded she would put a new process in place to better monitor prn psychotropic medication orders. The facility Medical Director commented on 07/18/19 at 4:00 PM that prn psychotropic medications were to be discontinued after 14 days unless the attending physician assessed the resident and directed staff to continue the order.	F 758	(ADON) weekly x 8 weeks then monthly x 1 month utilizing a Psychoactive Medication Audit Tool . This audit is to ensure that the duration of the PRN psychotropic medication is limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time in the medical records. The ADON, Clinical Coordinator, Staff Facilitator or QA nurse will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit. The DON will review and initial the Psychoactive Medication Audit Tools weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Psychoactive Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Psychoactive Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 761 SS=E	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	F 761		8/25/19

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F 761	Continued From page 67 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 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 observation and staff interviews the facility failed to keep unattended medication secured for 2 of 5 medication carts observed, and failed to remove expired insulin vials from 2 of 3 medication carts observed. Findings included: 1. In an observation on 07/15/19 at 4:49 PM a medication cart was against the wall between rooms 102 and 104. A round purple container was seen on top of the medication cart. Nurse #10 approached the cart within approximately 45 seconds and verified that the container had the medication Advair in it. In an interview on 07/15/19 at 4:50 PM Nurse #10 stated that Advair was a medication that would be inhaled by a resident. He stated that medications	F 761	On 7/18/19, the assigned nurse removed all expired medications on the 500 hall medication cart and the 600/700 hall medication cart. Replacement medications were ordered from pharmacy with oversight by the Director of Nursing (DON) on 7/18/19. Nurse #10 secured the Advair from the top of the medication cart on 7/15/19 with oversight by the clinical Coordinator. Nurse #13 was in-serviced regarding locking the medication cart on 8/8/19. On 7/24/19, 100% audit of all medication carts to include the medication cart on the 500 hall and on the 600/700 hall was	

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F 761	Continued From page 68 should not be left on top of the medication cart. He indicated that anyone could take the medications from the top of the cart if left there. Nurse #10 stated that he did not usually leave medications on top of the medication cart. In an interview on 07/20/19 at 3:42 PM the Director of Nursing stated that medications should not be left on top of unattended medication carts because anyone could take them and that it was a safety issue. 2. In an observation on 07/16/19 at 4:41 PM a medication cart was outside the open door of room 500. The resident was up in a wheelchair in the room and was able to maneuver to the doorway if he wanted to. The lock of the medication cart did not appear to be engaged. At 4:42 PM Nurse # 13 came around the corner of the nursing station and approached the medication cart. She verified that the medication cart had been left unlocked and unattended. In an interview on 07/16/19 at 4:42 PM Nurse #13 stated that she should not have left the medication cart unlocked. She indicated that she went to get cups for her cart and that she must not have locked the medication cart. Nurse #13 stated that medication carts should not be left unlocked because residents or visitors could take the medications. In an interview on 07/20/19 at 3:42 PM the Director of Nursing stated that unlocked medication carts should not be left unattended due to safety issues. She indicated that if medication carts were left unlocked then anyone could open the cart and take the medications.	F 761	completed by the Director of Nursing (DON), Clinical Coordinator, Quality Assurance Nurse (QA Nurse), and Staff Facilitator. The audit is to ensure no expired medications were stored in the medication carts, no medications were stored on top of the cart and that all carts were locked when not supervised by assigned nurse. The Clinic Coordinator, Staff Facilitator, and QA nurse addressed all concerns identified during the audit to include removal of expired medication, securing medications per facility protocol and education of staff. 100% in-service was initiated by the Staff Facilitator on 7/17/19 with all nurses and medication aides to include nurse # 10, nurse # 12, nurse # 13 and nurse # 14 in regards to Medications. This in-service emphasis was on (1) checking medications before administration for expired dates (2) appropriately discarding expired medications per pharmacy policy, and (3) storage of medication and (4) securing the medication cart when not directly supervised by the assigned nurse. In-service will be completed by 8/25/19. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regards to Medications. 10% Audit of all medication carts will be monitored by the Clinic Coordinator, ADON, Staff Facilitator and QA Nurse weekly x 8 weeks then monthly x 1 month utilizing the Medication Audit Tool. This audit is to ensure no expired medications	

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F 761	Continued From page 69 3. a. In an observation and interview on 07/18/19 at 11:27 AM the 500 hall medication cart was unlocked and opened by Nurse #14. One vial of Humalog insulin had been accessed and had an opened date of 06/11/19 written on it. The label on the vial directed that the vial be discarded 28 days after opening. Nurse #14 verified that the insulin should have been discarded when the 28th day was reached. She indicated that it was the responsibility of each nurse during shift change to check the expiration dates of the insulin on the medication cart. Nurse #14 stated that she should have discovered the expired insulin at shift change that day. In an interview on 07/20/19 at 3:42 PM the Director of Nursing stated that insulin on each medication cart was to be checked every shift during shift change. She indicated that expired insulin should not be left on the medication cart because if used, it could affect the effectiveness of the medication. b. In an observation and interview on 07/18/19 at 11:40 AM the 600/700 hall medication cart was unlocked and opened by Nurse #12. One vial of Lantus insulin had been accessed and had an opened date of 06/12/19 written on it. There was no directive about how many days after opening and accessing, that the insulin should be discarded. Nurse #12 was unsure how many days after opening that the Lantus insulin should be discarded. (Lantus insulin should be discarded 28 days after accessing). Nurse #12 indicated that every nurse who took over the cart had the responsibility of checking the insulin for the expiration dates and discarding the ones that had expired.	F 761	were stored in the medication carts, no medications were stored on top of the cart and that all carts were locked when not supervised by assigned nurse. The nurse and/or medication aides will be immediately re-trained by the Staff Facilitator, Clinical Coordinator, ADON or QA nurse for any identified areas of concern. The DON will review and initial the Medication Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The DON will present the findings of the Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 761	Continued From page 70 In an interview on 07/20/19 at 3:42 PM the Director of Nursing stated that insulin on each medication cart was to be checked every shift during shift change. She indicated that expired insulin should not be left on the medication cart because if used, it could affect the effectiveness of the medication.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to obtain pre-albumin and albumin laboratory tests as ordered by a physician for 1 of 8 residents (Resident #67) who was reviewed for laboratory results. Findings included: Resident #67 was admitted to the facility on 07/30/15 and had diagnoses of hemiplegia, diabetes, and muscle weakness. Review of the resident's 05/28/19 Wound Clinic Visit Report revealed under Additional Orders: Other Orders- (facility) please draw Albumin and	F 773	On 8/9/19, the provider was notified of labs not being completed per wound clinic recommendations for resident # 67. A new order obtained on 8/9/19 by the Director of Nursing (DON) to discontinue lab as no longer indicated. On 8/5/19 100% audit was initiated by the Quality Assurance (QA) Nurse, Resource Nurse, and Clinic Coordinators of all current residents to include resident # 67 consult reports to include wound clinic reports for the past 30 days. This audit is	8/25/19

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F 773	Continued From page 71	F 773		

Prealbumin and fax results to (telephone number).

Review of the quarterly Minimum Data Set (MDS) dated 05/29/19 revealed that Resident #67 was severely cognitively impaired and did not reject care. Resident #67 was at risk for and had two stage three pressure ulcers.

Review of Resident #67's Care Plan revealed a focus of ulceration of skin caused by prolonged pressure related to two stage three pressure ulcers. Interventions included to maintain the wound physician consults and visits, treatments as ordered, and to obtain laboratory work as ordered.

Review of Resident #67's May 2019 laboratory results did not reveal any evidence that an Albumin and Prealbumin had been sent to the laboratory for testing.

Review of the resident's 06/06/19 Wound Clinic Visit Report revealed under Additional Orders: Other Orders- (facility) please draw Albumin and Prealbumin and fax results to (telephone number).

Review of Resident #67's June 2019 laboratory results did not reveal any evidence that an Albumin and Prealbumin had been sent to the laboratory for testing.

In an interview on 07/19/19 at 4:37 PM Unit Coordinator #2 stated that the wound care clinic sent progress notes back with the residents following their appointments. She indicated that those notes would contain any orders such as changes to treatments, medications, or to request

to ensure all labs were completed per physician order and that the physician and resident/resident representative were notified of the lab results. The QA nurse and Clinic Coordinators will address all identified concerns during the audit to include notification of the physician for further orders and/or completion of lab. Audit will be completed by 8/25/19.

On 8/7/19 100% in-service of all nurses to include Unit Coordinator #2 was initiated by the Staff Facilitator in regards to Following Physician Orders from Consults to include obtaining labs and the lab process. In-service to be completed by 8/25/19. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Following Physician Orders from Consults.

10% audit of all resident consult reports to include resident # 67 to include wound clinic reports will be completed by the Clinic Coordinator, Nurse Supervisor, Staff Facilitator and QA Nurse utilizing a Lab Order Audit Tool. This audit will be completed weekly x 8 then monthly x 1 month to ensure all labs are completed per the consulting physician order. All identified areas of concerns will be addressed during the audit by the Clinic Coordinator, Nurse Supervisor, Staff Facilitator and QA Nurse notification of the physician for further orders and/or completion of lab and staff re-training as indicated. DON will review and initial the Lab Order Audit Tool weekly x 8 weeks then monthly x 1 months to ensure all labs

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F 773	Continued From page 72 lab tests. She indicated that she was unaware that the wound clinic had requested the facility to draw labs for Resident #67. Unit Coordinator #2 stated that the Wound Clinic Progress Note was different from the Wound Clinic Visit Report that was faxed to the facility following the appointment but was unable to produce a Wound Clinic Progress Note from 05/28/19 or 06/06/19. In an interview on 07/19/19 at 4:50 PM the Medical Records clerk stated that when reports were faxed to the facility, she scanned them into the computer right away. She indicated that the nurses were supposed to be checking the reports in the computer for any changes to orders or for new orders. She indicated that she did not inform the nurses if any orders were listed on the reports. The Medical Records clerk was unable to produce any Wound Clinic Progress Notes from 05/28/19 or 06/06/19. In an interview on 07/20/19 at 3:42 PM the Director of Nursing (DON) stated that she expected the Unit Coordinator to review the progress notes and reports from the wound clinic and to document and carry out any new orders. She indicated that this should prevent any missed orders.	F 773	completed per Physician order. The DON will present the findings of the Lab Order Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Lab Order Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		8/25/19

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F 812	Continued From page 73 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry kitchenware prior to stacking it in storage, failed to cover food items when flies were present in the kitchen, failed to keep the kitchen free from dust/dirt/grease build-up/mold-like formation, and failed to monitor labeling and dating in storage areas. Findings included: 1. During initial tour of the kitchen, beginning at 11:42 AM on 07/15/19, 2 of 5 tray pans stacked on top of one another on a storage rack had moisture trapped in between them, and 2 of 3 large metal bowls stacked on top of one another on the same rack also had moisture trapped between them. During an interview with the Dietary Manager on 07/19/19 at 11:32 AM she stated she thought the kitchenware stacked wet in storage was washed earlier the same morning it was found, but this practice posed a safety risk because bacteria and mold could grow in the trapped moisture, potentially causing residents to get sick. She reported dietary staff had been trained to make	F 812	On 7/15/19, the Dietary Manager removed all metal bowls found to be stacked wet, re-washed the bowls and air dried per facility protocol. On 7/15/19, the Dietary Manager removed and discarded all items left uncovered to include but not limited to biscuits and dessert cups. On 7/15/19, the Maintenance Director notified the Pest Control Company in regards to pests in the kitchen. An appointment was scheduled for 7/16/19. On 7/16/19, The Pest Control Company treated all problem areas for pests to include the kitchen. The Pest Control Company will make monthly and as needed inspections on an ongoing basis for pest control to include treating all rooms, common areas, kitchen and entrances as indicated. On 7/15/19, all opened food items that were found not dated/labeled or out of compliance were discarded by the Dietary Manager and Dietary Assistant. On 7/15/19, the Dietary Consultant	

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F 812	Continued From page 74 sure kitchenware was clean and dry before stacking it in storage. During an interview with Dietary Aide #1 on 07/19/19 at 2:02 PM she stated the facility had drying racks where kitchenware was supposed to be air dried before being stacked in storage. She reported stacking kitchenware with moisture trapped inside caused germs to develop and multiply. 2. During initial tour of the kitchen, beginning at 11:42 AM on 07/15/19, there were multiple flies observed in the kitchen. Further observations revealed the following foods were uncovered and unprotected from possible contamination: a small pan of biscuits sitting on top of an oven was uncovered and barely above room temperature, a large pan of biscuits was uncovered and resting on top of a covered steam well of the kitchen's trayline. The large pan was warm, but not hot to the touch. An open cart which contained trays of peaches and cream had been pushed into the walk-in refrigerator in order to chill the fruit. However, 5 of 6 trays of the dessert were uncovered. During an interview with the Dietary Manager on 07/19/19 at 11:32 AM she stated food items should be covered unless they were subjected to heat over 165 degrees Fahrenheit to prevent cross- contamination from pests and debris such as dust and dirt. During an interview with Dietary Aide #1 on 07/19/19 at 2:02 PM she stated flies could land on food items that were uncovered in the kitchen, spreading germs and bacteria. She reported parchment paper and plastic wrap could be used	F 812	completed a 100% audit of all kitchenware to ensure all kitchenware was dried per facility protocol and not stored wet. There were no additional identified concerns during audit. On 7/15/19, the Dietary Manager completed a 100% audit of food items to ensure no items were left uncovered or exposed to pests in the kitchen. There were no additional identified concerns during the audit. On 7/15/19 the dietary staff under the supervision of the Dietary Manager and Dietary Consultant initiated cleaning of the all kitchen areas to include but not limited to the microwave, utensil drawers, fans, baseboards, under equipment, ice machines, fryers and around drainage grates. Cleaning was completed on 7/17/19. On 7/15/19, the Dietary Manager and the Dietary Assistant completed a 100% audit of all food items under the supervision of the Dietary Consultant to ensure all items were dated and label when opened and that no items were out of compliance. All identified concerns were immediately addressed by the Dietary Manager, Dietary Assistant and Dietary Consultant during the audit to include discarding items found not dated/labeled or out of compliance and education of staff. On 7/15/19 100% in-service was initiated by the Dietary Consultant with all kitchen staff in regards to (1) Wet Nesting (2) Label/dating and expired foods (3) Cleaning of Kitchen Areas and (4) Pest control with emphasis on covering food items. All in-services will be completed by	

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F 812	Continued From page 75 to protect these food items. 3. During an initial tour of the kitchen, beginning at 11:42 AM on 07/15/19, the sides and top of the microwave were caked with dried food particles, an utensil drawer had dried food particles on the lip of the drawer and down inside the drawer where utensils were being stored, and a fan blowing into the dish machine area had dust and dirt clinging to the front and back facings. There was a build-up of dirt, dried food particles, wrappers and straws, and a silt-like material along the baseboards of the perimeter walls of the kitchen, with the greatest accumulation being in the dish machine area and under racks and kitchen equipment. The floor under the deep fryer and a table beside the deep fryer had a heavy film of old grease and oil on them, and a grate/drain cover in front of the deep fryer was black with a build-up of grease/oil and dried food. During a follow-up tour of the kitchen on 07/17/19 at 9:14 AM a black gooey mold-like substance was found accumulated at the far end of the scoop holder attached to the ice machine. The floor under the deep fryer and a table beside the deep fryer were still coated in a heavy film of old grease and oil, and the grate/drain cover had not been cleaned. During an interview with the Dietary Manager (DM) on 07/19/19 at 11:32 AM she stated the dietary aides were supposed to clean the fan faces as needed, but this duty did not appear on a list of scheduled cleaning tasks. She reported dirty fans could contaminate kitchenware that was being sanitized during the dish machine process. According to the DM, dietary staff were supposed to clean all interior surfaces of the microwave	F 812	8/25/19. 10% audit of kitchenware will be completed by the Dietary Manager and/or Dietary Assistant to ensure all kitchenware was dried per facility protocol and not stored wet. 10% audit of all food items will be completed by the Dietary Manager and/or Dietary Assistant to ensure no foods items are left uncovered or exposed to pests. 10% audit of all kitchen areas will be completed by the Dietary Manager and/or Dietary Assistant to ensure all kitchen areas to include but not limited to the microwave, utensil drawers, fans, baseboards, under equipment, ice machines, fryers and around drainage grates were cleaned per facility protocol. Audits/observations will be completed 3 times a week x 8 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. All areas of concern will be addressed by the Dietary Manager and/or Dietary Assistant to include (1) re-washing and air drying kitchenware (2) removing all food items not properly dated/label or out of compliance and (3) cleaning of kitchen for identified concerns. The Administrator will review the Kitchen Audit Tool 3 times a week x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will present the findings of the Kitchen Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Kitchen Audit Tool to determine trends and/or issues that may need further interventions put into place	

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F 812	Continued From page 76 after each use, and the utensil drawers were supposed to be wiped out a couple of times each day. She commented that dried food particles could contaminate food being heated in the microwave and could contaminate utensils that had been sanitized in the three-compartment sink system. The DM stated the baseboards along perimeter walls were supposed to be swept and mopped along with the main kitchen floors twice daily. She reported that dirty floors and dirty grates/drains and the accumulation of old grease and oil on kitchen surfaces increased the chance the kitchen could experience pest control problems. The DM commented mold-like build-up in the scoop holder could end up cross-contaminating the ice placed in resident beverages, with the potential of making residents sick. During an interview with Dietary Aide #1 on 07/19/19 at 2:02 PM she stated maintenance was responsible for cleaning the kitchen fans, but she was not sure how frequently it was done. She reported the microwave and utensil drawers were to be wiped down with a sanitizing solution daily to keep food and utensils from being cross-contaminated. The aide commented the floors and along the baseboards were swept and mopped twice daily. According to Dietary Aide #1, dirty floors and the build-up of old grease and oil in the kitchen could attract flies, gnats, and roaches. She stated she thought the ice scoop and scoop holder were supposed to be wiped down with sanitizer twice daily in order to prevent germs from getting into ice as it was put into resident beverages. 4. During initial tour of the kitchen, beginning at 11:42 AM on 07/15/19, a 16-ounce package of	F 812	and to determine the need for further frequency of monitoring.	

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F 812	Continued From page 77	F 812		

Alfredo sauce mix in the dry storage room had been opened without a label and open date on it. In the walk-in refrigerator gallon containers of zesty Italian dressing, mayonnaise, cooking sherry, and soy sauce had been opened, but had no open date documented on them. A storage container of pot roast was found in the walk-in refrigerator with a discard date of 07/13/19. In the walk-in freezer steaks in a storage bag, a package of hot dogs, two bags of chicken tenders, one bag of tater tots, and one bag of French fries were opened without labels and dates on them.

During an interview with the Dietary Manager (DM) on 07/19/19 at 11:32 AM she stated any dietary staff member who opened food items was responsible for documenting an open date on them. She also reported that she, her assistant, and the cooks were responsible for monitoring the storage areas at least daily to make sure labeling and dating was correct. She commented the labeling/dating system helped ensure the residents received the freshest foods possible. According to the DM, protein left overs such as the pot roast were only kept in refrigerated storage for five days, and then they were discarded. She stated that keeping high protein foods for more than five days in refrigerated storage increased the chance they could be used by mistake, with the potential of making residents sick if not reheated adequately.

During an interview with Dietary Aide #1 on 07/19/19 at 2:02 PM she stated all dietary employees were supposed to check dating and labeling when they entered storage areas. She reported a label was placed on all left overs which documented the date the food items were placed

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F 812	Continued From page 78 in storage and the date they were to be removed from storage and discarded. She commented when food items were kept past five days in refrigerated storage it increased the chance there could be spoilage. According to the aide, all food items which were opened, any food items which were repackaged, and left overs were supposed to be labeled and dated.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		8/25/19

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F 842	Continued From page 79 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the	F 842	All orders for resident # 29 will be	

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F 842	Continued From page 80 facility failed to document a physician's order on a resident's Medication Administration Record (MAR) for 1 of 33 resident records reviewed for accuracy (Resident #29). Findings included: Resident #29 was admitted to the facility on 06/04/16 with diagnoses that included Hemiplegia and hemiparesis following a nontraumatic intracerebral hemorrhage affect the left non dominant side, hyperosmolality and hypernatremia, dehydration, gastroparesis, gastrostomy status. An annual Minimum Data Set Assessment (MDS) dated 04/21/19 revealed Resident #29 had moderately impaired cognition, displayed no moods or behaviors, and was dependent for all care. He was always incontinent of bowel and bladder. He received scheduled and as needed pain medications. On seven days during the lookback period he received opioid pain medication. He had a feeding tube and received 51% or more of his nutrition through the tube. Hospital records documented on 12/31/18 at 6:41 PM the resident was treated in the emergency room. His feeding tube was replaced. A two-way abdomen x-ray showed a large amount of constipation air. The physician wrote the resident would be given some magnesium citrate through is PEG tube and discharged back to the facility. Nurse #10 documented on 12/31/18 at 10:00 PM: "Resident returned from (hospital) via family transport ...Received report from (family member) that resident is constipated. Hospital supplied with magnesium citrate. Verified orders with	F 842	reviewed by the Charge Nurse to ensure medication orders were transcribed accurately and documented after administration on the medication administration record (MAR) on 8/8/19. 100% of all residents to include resident # 29 orders from 7/1/19-8/8/19 were reviewed and compared to the Medication Administration Record (MAR) by the Charge Nurse to ensure medication orders were transcribed accurately and documented after administration on the medication administration record. The Clinic Coordinator will address all areas of concern identified during the audit. Audit will be completed by 8/25/19. An in-service was initiated on 8/7/19 by the Staff Facilitator with 100% of nurses to include nurse #10 and nurse #4 regarding Medication Transcription and Documentation on the medication administration record. In-service will be completed by 8/17/19. All newly hired nurses will be in serviced during orientation by the staff facilitator in regards to Medication Transcription and Documentation. 10% of all resident□s to include resident # 29 newly written physician□s orders will be compared to the MAR by the Clinic Coordinator, Nurse Supervisor and Quality Assurance (QA) nurse weekly x 8 weeks then monthly x 1 month utilizing the Transcription/Documentation Audit Tool. This audit is to ensure that all orders were transcribed accurately to the MAR and is being documented on the MAR after administered. The nurses will be retrained by the Staff Facilitator for any identified	

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F 842	Continued From page 81	F 842		

Nurse Practitioner (NP) to give ½ bottle now and ½ bottle tomorrow evening. Monitor for bowel movement. Resident assisted to bed. Medications administered via G-tube, and tube feeding resumed. Scheduled pain meds given. No s/s of distress. Will continue with plan of care."

The following physician's telephone order was written by Nurse #10 on 12/31/18: "Magnesium Citrate 10 oz (ounce) - give 5 oz now and 5 oz tomorrow night per G-Tube for constipation." The time was not documented on the telephone order.

The December 2018 MAR revealed the magnesium citrate order was not transcribed or documented on the MAR. The second dose that was ordered by the NP to be administered the next night was, however, transcribed on the January 2019 MAR and documented by Nurse #11 as given on 01/01/19 at 8:00 PM.

Nurse #4 was interviewed on 07/16/19 at 4:50 PM. He did not recall that Resident #29 had been to the emergency room on 12/31/18 and reviewed his nursing notes to refresh his memory. He stated he had been confused that night because he had not received a written order from the physician at the hospital. When the resident returned from the emergency room, he had been handed a bottle of magnesium citrate by the family, told that the resident was constipated, and how the hospital physician wanted the laxative given. He stated he called the facility NP, received a telephone order to give the laxative and wrote the order. He was sure he gave the "now" dose of magnesium citrate on 12/31/18 even though it was not documented on the MAR because he "wouldn't not give it." He commented

areas of concern. The DON will review and initial the Transcription/Documentation Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.
The DON will present the findings of the Transcription/Documentation Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Transcription/Documentation Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 842	Continued From page 82 that he might have missed putting the order on the December MAR because it was change over night and he was very busy. In an interview with the Director of Nursing on 07/19/19 at 10:20 AM she stated when a resident returned from the hospital with recommended orders the nurse was to call the facility provider and get approval for the orders. The nurse was to then carry out the orders that were approved-including the documentation of the orders on the MAR.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		8/25/19

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F 880	Continued From page 83 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 84 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain infection control protocol by not removing dirty gloves after performing wound care to a stage 4 pressure ulcer then handling the residents bed control device to position the resident for 1 of 1 sampled resident. (Resident #50). Findings included: The facility Infection Prevention and Control Policy was reviewed. The policy indicated that hand hygiene procedures were to be followed by all staff who were involved in direct resident contact. In an observation on 7/17/19 at 9:40 AM with the wound treatment nurse (Nurse #1), wound care was performed for Resident #50. Three areas, a right gluteal fold stage IV pressure ulcer, a stage II pressure ulcer on the left buttocks, and a stage III pressure ulcer on the sacrum was observed. Each of the three pressure wounds were cleansed with Dakin's solution and covered with a bandage. Nurse #1 gathered supplies, washed her hands, and donned clean gloves, she changed and discarded her gloves between each of the three dressing changes. After completing the last wound she did not discard her gloves and proceeded to remove Resident #50's incontinent brief. Nurse #1 then handled the bed control device to reposition the resident while still wearing the dirty gloves. Resident #50 had a urinary catheter in place, and his brief was not soiled.	F 880	On 7/17/19, the bed control for resident # 50 was cleaned by the treatment nurse with oversight by the Minimum Data Set Nurse (MDS). Nurse # 1 was in-serviced and perform return demonstration on wound care to include removing gloves and washing hands prior to touching objects in the resident room to include the bed control on 8/6/19 by the Registered Nurse. The Assistant Director of Nursing (ADON), QA Nurse, Staff Facilitator and Nurse supervisor will observe 100% of all nurses to include nurse # 1 and medication aides perform a return demonstration on wound care. This observation is to ensure that all nurses successfully demonstrate removal of gloves and washing hands after performing a dressing change and prior to touching objects in the resident□s room to include bed controls. The nurse and/or medication aide will be retrained for any identified areas of concern during the audits. Observations will be completed by 8/25/19. An in-service was initiated on 8/7/19 by the Staff Facilitator with 100% of all nurses to include Nurse # 1 and medication aides regarding infection control with an emphasis removing gloves and washing hands after a dressing change prior to touching objects in the room to include bed controls. This in-service will be completed by 8/25/19.	

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F 880	Continued From page 85 In an interview on 7/17/19 at 9:50 AM. Resident #50 stated his brief had been changed during his bath earlier that morning. In an interview on 7/17/19 at 10:00 AM with the wound treatment nurse (Nurse #1) she stated she forgot to discard the dirty gloves before handling Resident #50's bed control device due to her being nervous. She immediately went back into Resident #50's room and disinfected the bed control device. In an interview conducted on 7/20/19 at 1:38 PM with the Director of Nursing (DON), she acknowledged that the dirty gloves should have been discarded immediately following the dressing change. She stated the nurses are expected to follow infection control protocols while performing wound care.	F 880	All newly hired nurses will receive the in services during orientation by the Staff Facilitator. The ADON will observe 10% of nurses and/or medication aide to include nurse # 1 who provide wound care weekly x 8 weeks then monthly for 1 month utilizing a Resident Care Audit Tool. This audit is to ensure that nurses remove gloves and wash hands after performing wound care and prior to touching objects in the room to include but not limited to the bed control. The nurse and/or medication aide will be immediately retrained during the audits for any identified areas of concern by the ADON. The Director of Nursing (DON) will review and initial the Resident Audit Tool weekly x 8 weeks then monthly for 1 month to ensure all identified areas of concern have been addressed. The Director of Nursing will forward the results of the Resident Care Audit Tools to the Executive QI Committee monthly x 3 months. The Executive QA committee will meet monthly for 3 months to review the Resident Care Audit Tools for trends and/ or issues and to determine the continued need and frequency of monitoring.	