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	345153	A. BUILDING _____ B. WING _____	C 08/01/2019

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TRINITY OAKS	820 KLUMAC ROAD SALISBURY, NC 28144

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E 000	Initial Comments An unannounced Recertification and compliant investigation survey was conducted on 7/29/19 through 8/1/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #K3LK11.	E 000		
F 000	INITIAL COMMENTS A recert and complaint survey was conducted from 7/29-8/1/2019 Event # K3LK11. 1 of the 4 complaint allegations was substantiated resulting in deficiencies F561 D.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to assess 1 of 1 resident, Resident #88, for the ability to self-administer medications safely. Findings included: Resident #88 was admitted to the facility on 8/13/18 with diagnoses of heart failure, diabetes, neuropathy, and hypertension. A Physician's Order dated 2/12/19 stated Resident #88 may apply an antifungal powder to her abdominal fold topically 2 times a day and she may apply Icy Hot Smart Relief, a topical pain reliever, as needed and keep it at her bedside.	F 554	Resident #88 was not assessed properly by her nurse before self-administering anti-fungal powder due to staff education. Resident #88 was assessed by Assistant Director of Nursing (ADON) on 7/31/19 for ability to self-administer medications. Assessment found resident is safe to administer anti-fungal medication. Resident #88's care plan was updated to show that she self-administers her anti-fungal medications by Minimum Data Set Coordinator on 8/1/19. Nurse that received physicians order for resident #88 to self-administer anti-fungal	8/27/19

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

Electronically Signed | 08/20/2019

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F 554	Continued From page 1 A review of Resident #88's Care Plan revealed a Memory and Communication Care Plan updated on 7/11/19 that stated she had a short attention span and may be unable to make good decisions for herself and her health. The most recent Annual Minimum Data Set Assessment dated 7/16/19 revealed Resident #88 was cognitively intact and required limited assistance with bed mobility and transfers. During an interview with Resident #88 on 7/29/19 at 10:31 am she stated she had a rash to her left axillary and under her breasts. She stated she had a powder she applied to the area herself. She indicated she kept the medication in her night stand. A Self Administration of Medication Assessment dated 7/31/19 revealed Resident #88 was able to self-administer the antifungal powder that was ordered on 2/12/19. There was not a Self Administration of Medication Assessment completed before 7/31/19. During an interview with the Director of Nursing on 7/31/19 at 9:45 am she stated Resident #88 treated her rash herself and kept the medication in her room. During an interview with the Nurse Practitioner on 8/1/19 at 9:15 am she stated that Resident #88 was given an order to apply antifungal powder to her abdominal fold as needed and she was safe to apply her own medications. The Nurse Practitioner also stated she was not aware Resident #88 had a rash to her left axillary area or under her breast or that Resident #88 was	F 554	powder was coached on proper completion of self-administration assessment for all residents prior to self-administering medications by Staff Development Coordinator (SDC) on 8/9/19. An audit of all residents' Medical Record was conducted by Staff Development Coordinator to identify all residents that self-administer medications on 8/8/19. The audit found that no other residents self-administer medications. Medication self-administration assessment has been updated to include assessing residents based on the specific medications they desire to self-administer. All nurses were in-serviced on proper completion of medication self-administration assessment prior to allowing residents to self-administer medications by Staff Development Coordinator by 8/24/19. All new nurses will be in-serviced on properly assess a resident prior to allowing them to self-administer medications by the staff development coordinator during orientation. Medication self-administration assessment will be conducted during quarterly resident assessments by Minimum Data Set Coordinator for any resident with an order to self-administer medications. Any resident experiencing a significant change in condition who has an	

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F 554	Continued From page 2 using the antifungal powder for those areas. During an observation and interview with Resident #88 on 8/1/19 at 10:41 am she stated the rash on her left underarm and under her breasts had healed. An interview with the Unit Manager #1 on 8/1/19 at 12:23 pm revealed Resident #88 had an order to self-administer a powder and cream at her own discretion until yesterday, 7/31/19. She stated the orders were discontinued on 7/31/19. A follow up interview with the Unit Manager on 8/1/19 at 12:23 pm revealed Resident #88 had a Self-Administration of Medication Assessment completed on 7/31/19 but did not have the assessment completed when the order was received for Resident #88 to self-administer her own medications. The Director of Nursing was interviewed on 8/1/19 at 3:54 pm and stated she expected the Medication Administration Assessment to be completed prior to a resident receiving a self-administer medication. She stated the resident should be assessed to ensure they are competent to administer the medication. An interview with the Administrator on 8/1/19 at 4:42 pm revealed his expectation of staff would include an assessment of the resident before giving them a medication to self-administer. He indicated he expected the staff to ensure the safety of the residents when allowing them to administer their own medications.	F 554	order to self-administer medication will be reassessed to ensure the resident is able to continue to safely self-administer medications. The care plan will be revised to reflect the status of the resident's ability to self-administer medications by the Minimum Data Set Coordinator, Staff Development Coordinator, or Director of nursing at that time. Nurse Unit Supervisors, Assistant Director of Nursing, Director of Nursing, or Staff Development Coordinator will audit 5 residents' medical records per week for one month, 3 residents' medical records per week for one month, and 2 residents' medical records per week for one month to ensure all residents that self-administer medications are properly assessed. Any errors found will be corrected at that time. Audit results will be reviewed and monitored through monthly Quality Assurance Performance Improvement meetings and addressed by the Interdisciplinary Team as needed. The director of nursing is responsible for this plan of correction.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		8/27/19

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F 561	Continued From page 3 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident, family member and staff interviews, the facility failed to honor a resident ' s sleeping schedule for 1 of 1 resident reviewed for choices (Resident #64). Findings included: Resident #64 was admitted to the facility on	F 561	Resident #64 was not given the opportunity to choose sleeping schedule due to staff training error. Residents #64's care plan was updated to include desired sleep schedule by Minimum Data Set Coordinator on 7/25/19.	

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F 561	Continued From page 4 6/17/2019 with diagnoses to include fractured humorous (arm) and Parkinson ' s disease. The most recent admission Minimum Data Set (MDS) assessment dated 7/1/2019 assessed Resident #64 to be without physical or verbal behaviors and no rejection of care, and he required extensive 2-person assistance with bed mobility, transfers and toileting. The admission MDS dated 7/1/2019 assessed him to be frequently incontinent of urine and always incontinent of bowels and having moderate cognitive impairment. Resident #64 was interviewed on 7/30/2019 at 8:27 AM. Resident #64 reported he had told the nursing staff prior to 7/20/2019 he did not want to be disturbed from 10:30 PM until 6:30 AM to prevent interrupting his sleep. Resident #64 reported he was not certain who he told, but he and his family member had expressed his choice to the nursing staff on two different occasions. Resident #64 stated on 7/20/2019 at approximately 1:00 AM, Nurse #3 and nursing assistant (NA) #3 woke him up to provide incontinence care and he told them to leave him alone. Resident #64 explained that Nurse #3 told him his wet incontinence brief needed to be changed and proceeded to change the brief with the assistance of NA #3. Resident #64 reported the incident made him feel angry that his sleep was interrupted. Resident #64 ' s family member (FM)#1 was interviewed on 7/30/2019 at 4:41 PM. FM #1 reported prior to 7/20/2019 she had made requests to two floor nurses not to disturb Resident #64 ' s sleep during the night from 10:30 PM until 6:30 AM for incontinence care.	F 561	Nurse Aid #3 and Nurse #3 were coached on residents' right to choose sleeping schedule by Staff Development Coordinator on 7/22/19. All residents that are able to express their preference were interviewed by Administrator, Director of Nursing, Assistant Director of Nursing, Social Workers, and Unit Nurse Supervisors on 8/19/19 and 8/20/19 to ensure their desired sleep schedule was being followed by staff. The audit determined that 5 residents' desired a different sleep schedule. Those residents' care plans were updated by Minimum Data Set Coordinator on 8/21/19. All nursing staff were in-serviced on residents' right to choose sleeping schedule by Staff Development Coordinator on 7/25/19 through 7/29/19. All residents that are able to express their preferences will be interviewed for desired sleep schedule by Life Enrichment Director during quarterly resident assessments. Results of these interviews will be shared with Minimum Data Set Coordinator upon completion. Residents' care plans will be updated to reflect desired changes to preferred sleep schedule by Minimum Data Set Coordinator at that time. Social Worker or Life Enrichment Director will interview all residents that are able to express their preferences to ensure desired sleep schedule is being followed during quarterly resident assessments.	

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F 561	Continued From page 5 Nurse #3 was interviewed on 7/31/2019 at 5:40 AM and she reported she had performed incontinence care on Resident #64 at 1:00 AM on 7/20/2019 because he was saturated with urine and she was concerned about the condition of his skin. Nurse #3 reported that she was aware that Resident #64 did not want his sleep to be disturbed at night prior to 7/20/19. Nurse #3 went on to describe Resident #64 had reddened perineal skin and she was worried if he laid in a urine saturated incontinence brief, the skin would breakdown and he would develop a wound. Nurse #3 further reported Resident #64 had intermittent confusion. NA #3 was interviewed on 7/31/2019 at 2:42 PM and he reported he had assisted Nurse #3 with incontinence care for Resident #64 on 7/20/2019. NA #3 reported he had written instructions given by Nurse #3 to check Resident #64 for incontinence at 1:00 AM, 3:00 AM and 5:00 AM. NA #3 reported he had checked on Resident #64 at 1:00 AM on 7/20/2019 and Resident #64 refused incontinence care, so NA #3 reported to Nurse #3 the refusal. NA #3 explained he had assisted Nurse #3 to change Resident #64 ' s wet incontinence brief by retrieving a clean and dry pad, as well as a clean brief. The Director of Nursing (DON) was interviewed on 8/1/2019 at 4:25 PM and she reported Nurse #3 was concerned about the condition of Resident #64 ' s skin and had instructed NA #3 to check on him for incontinence to prevent skin breakdown related to exposure to urine. The DON went on to explain both Nurse #3 and NA #3 had received 1:1 instruction and training regarding resident choice and to document the	F 561	Any sleep schedule that is not being followed will be reported to Director of Nursing and addressed at that time. All residents' preferred sleep schedule is available to all nursing staff through Nurse Aid Kardex. All nursing staff will be in-serviced on how to locate residents' preferences on Nurse Aid Kardex by Staff Development Coordinator by 9/4/19 or before beginning next scheduled shift. All new nursing staff will be in-serviced on residents' right to choose sleeping schedule and use of Nurse Aid Kardex to locate residents' sleep preferences by Staff Development Coordinator during orientation. Director of Nursing, or Social Worker will audit 5 residents per week for three months to ensure preferences in sleep schedules are being followed. Audit results will be monitored at monthly Quality Assurance Performance Improvement meetings, and addressed by the Interdisciplinary team. The director of nursing is responsible for this plan of correction.	

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F 561	Continued From page 6 refusal of care, and communicate that refusal to the facility staff, physician and family. The DON concluded by reporting a resident had the right to refuse care, the facility staff should respect and honor their refusal. The Administrator was interviewed on 8/1/2019 at 4:56 PM and he reported that Nurse #3 ' s intentions were to prevent skin breakdown for Resident #64. The Administrator reported the facility had performed 100% education of all staff regarding resident ' s right to refuse care and choices but did not have a procedure in place to monitor the results of the training. The Administrator went on to explain it was his expectation that all residents had the right to choose their care and the right to refuse care, even if that refusal was not in the resident ' s best interest and the Administrator expected staff to honor the choices of the residents.	F 561		
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 interviews the facility failed to assist 1 of 4 residents (Resident #13) with nail care and 1 of 4 residents (Resident #62) with feeding assistance, for resident's dependent for care with activities of daily living. Findings included:	F 677	Facility failed to cut and clean resident #13's nails due to staff training Resident #13's Assigned Nurse and Assistant Director of Nursing cut and cleaned resident #13's fingernails on 8/1/19. A visual audit of all residents' fingernail	8/27/19

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F 677	Continued From page 7	F 677		

1. Resident #13 was admitted to the facility on 10/30/17 with diagnoses of contracted left upper extremity, hemiplegia, Parkinson's Disease and dementia.
The most recent annual Minimum Data Set (MDS) Assessment dated 5/15/19 revealed Resident #13 required extensive assistance with bathing. The assessment further revealed Resident was moderately cognitively impaired.

During an observation on 7/29/19 at 9:55 am Resident #13's fingernails were ¼ inch long and there was dark brown material under his nails. Resident #13 had a splint on his left hand.

An observation of Resident #13 on 8/1/19 at 9:50 pm revealed he had a splint to his left hand and his fingernails were 1/4-inch-long and there was dark brown material under his nails.

During an interview with Nurse Aide #1 on 8/1/19 at 11:30 am she stated the Nurses trimmed the resident's nails. She stated when she puts the splint on Resident #13 and takes it off, he will pull his hand away from you, but he is not combative.

An interview and observation on 8/1/19 at 2:58 pm with Nurse #1 revealed the Nurses addressed the resident's nails during the skin assessment done every week and as needed. She stated the Nurse either trim the resident's nails or they can assign it to a Nurse Aide. Nurse #1 stated everyone should be assessing Resident #13's nails due to the splint he had on his left hand. Resident #13's nails were observed with Nurse #1 and she stated the nails were ¼ inch long and needed to be cleaned. Nurse #1 held Resident #13's left hand and inspected his nails and he did not pull away from her.

length and cleanliness was conducted by Unit Nurse Supervisors, Assistant Director of Nursing, and Unit Charge Nurses on 8/14/19, 8/15/19, and 8/16/19. The audit determined 36 residents required nail care. Nail care was provided at that time by the residents' assigned nurse at the time of the audit.

All nursing staff will be in-serviced on proper nail care by Staff Development Coordinator by 8/24/19, or prior to beginning their next assigned shift.

All new nursing staff will be in-serviced on proper nail care by Staff Development Coordinator during orientation.

Care plans will be updated during quarterly assessments by the MDS nurse as appropriate.

Nurse Unit Supervisor, Assistant Director of Nursing, or Director of Nursing will conduct a visual audit of 10 residents' finger nail hygiene a week for 4 weeks, 5 residents' finger nail hygiene a week for 4 weeks, and 3 residents' a week for 4 weeks. Any improper nail care will be corrected at that time by Nurse Unit Supervisor or Charge Nurse.
Audit results will be reviewed and monitored through monthly Quality Assurance Performance Improvement meetings and addressed by the Interdisciplinary Team as needed.

Facility failed to assist resident #62 with eating due to staff training

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F 677	Continued From page 8 During an interview with the Director of Nursing on 8/1/19 at 3:56 pm she stated the resident's nails should be trimmed during the skin check that are completed weekly and as needed. She also stated Resident #13's left hand should be assessed frequently due to the splint he wears daily. On 8/1/19 at 4:40 pm the Administrator stated all resident's nails should be clean and a safe length. 2. Resident #62 was admitted to the facility on 12/4/14 with diagnoses of dementia and psychotic disorder. The Care Plan dated 6/28/19 stated Resident #62 was at risk for choking due to chewing difficulties and required set up and assistance with meals. The most recent Quarterly Minimum Data Set (MDS) Assessment dated 7/3/19 revealed Resident #62 was severely cognitively impaired and required extensive assistance with eating. On 7/30/19 at 8:03 AM Resident #62 was observed sitting up in bed with her breakfast tray on the table over her bed. Resident #62 was not able to bring food to her mouth and attempted multiple times. She stated she was not able to eat her breakfast. Resident #62 was observed attempting without success to bring a cup with a straw to her mouth. An interview with the family member on 7/30/19 at 8:35 AM revealed Resident #62 required assistance with meals. During an interview with Nurse Aide (NA) #2 on	F 677	Resident #62's assigned Nurse Aid assisted her with eating breakfast on 7/30/19. Resident #62's intake for that meal was 75%. An audit of all residents' ability to feed themselves was conducted on 8/12/19, 8/13/19, and 8/14/19 by Staff Development Coordinator. The audit determined 24 residents required assistance eating. Those residents' care plans were updated to reflect their ability to feed themselves by Minimum Data Set Coordinator on 8/15/19 and 8/16/19. All nursing staff will be in-serviced on providing proper feeding assistance by Staff Development Coordinator by 8/24/19, or prior to beginning their next assigned shift. All new nursing staff will be in-serviced on proper feeding assistance by Staff Development Coordinator during orientation. Unit Nurse Supervisors or Unit Charge Nurses will audit residents requiring nutritional assistance at each meal to ensure that resident received required assistance when eating 5 times a week for one month, 3 times a week for one month, 2 times a week for one month. Any residents that do not receive needed assistance will be assisted by Nurse Unit Supervisor, Charge Nurse, or assigned nursing staff at that time.	

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F 677	Continued From page 9 8/1/19 at 12:06 PM, she stated Resident #62 needed to be assisted with feeding. NA #2 stated the staff knew who needed to be assisted with meals because it was on the electronic Kardex in the computer. On 8/1/19 at 12:10 PM an interview with Nurse #2 revealed Resident #62 required assistance with meals and should not be allowed to eat without assistance. Nurse #2 stated Resident #62 was identified by nursing to require assistance with meals and could not be left alone during meals. Nurse #2 stated Resident #62's tray should not be set up and left without staff being with her. Nurse #2 provided a list of residents that required assistance with meals that included Resident #62. The Director of Nursing (DON) stated, during an interview on 8/1/19 at 3:58 pm, that nurse staff made the determination if a resident should be fed. The DON stated Resident #62 should have been assisted with breakfast on 7/30/19 since she was on the facility list of residents to be assisted with meal. The DON stated the tray should not have been left without nursing supervision. The DON stated she did not know why Resident #62's tray was set up on 7/30/19 by staff when she should have been assisted with her all meals. She stated all residents on the list for assistance with meals should be assisted. During an interview with the administrator on 8/1/19 at 4:45 pm he stated all residents that were listed as needing assistance with feeding should have someone with them at all meals. The Administrator stated expected the staff to assist residents that needed assistance with meals.	F 677	Audit results will be reviewed and monitored through monthly Quality Assurance Performance Improvement meetings and addressed by the Interdisciplinary Team as needed. The director of nursing is responsible for this plan of correction.	

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F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a safe environment by storing a chemical cleanser in an opened shower room for 1 of 3 shower rooms observed (lower C-hall). Findings included: The lower C hall shower room was observed on 7/29/2019 at 9:48 AM. The door was open, and a bottle of cleanser labeled as ammonium chloride was observed on the half-wall beside the shower room ' s stall. The warning label on the ammonium chloride read "causes eye irritation; harmful if swallowed; may cause skin irritation, inhalation of vapors may cause respiratory irritation". Residents were observed in the hallway walking past the open shower doors. The lower C hall shower room was observed on 7/29/2019 at 3:03 PM. The door was open, and the bottle of cleanser labeled as ammonium chloride was noted to be on the half-wall beside the shower stall. The lower C hall shower room was observed on	F 689	Chemicals were left in shower room and shower room door was left open due to staff education error. The chemicals were removed from shower room and door closed on 8/1/19 by Environmental Services Director. All ambulatory residents and residents that can self-propel in wheel chairs or Broda chairs are potentially affected by deficient practice. Administrator conducted an audit of all facility shower rooms on 8/1/19 and found no other shower rooms had improperly stored chemicals and no other shower room doors were left open. All housekeeping staff and nursing staff will be in-serviced on safe chemical storage, including the importance of keeping shower room doors closed, by Staff Development Coordinator by 9/4/19, or before beginning their next assigned shift.	8/27/19

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	345153	A. BUILDING _____ B. WING _____	C 08/01/2019

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F 689	Continued From page 11 7/30/2019 at 10:23 AM. The door was propped open and a bottle of cleanser labeled as ammonium chlorides was noted to be on the half-wall beside the shower room ' s stall. An observation of the lower C hall shower room was conducted on 7/31/2019 at 5:55 AM. The bottle of cleanser labeled as ammonium chloride was observed to remain on the half-wall beside the shower stall and the door remained open. The lower C hall shower room was observed a final time on 8/1/2019 at 9:13 AM. The door was propped open and a bottle of cleanser labeled as ammonium chlorides was noted to be on the half-wall beside the shower room ' s stall and the door to the shower room was opened. Nursing assistant #5 was interviewed on 8/1/2019 at 9:13 AM and she reported the shower door should always be closed and she was not certain why it was open. An interview was conducted on 8/1/2019 at 9:16 AM with Housekeeper #1 and she reported the shower room doors should always be closed. Housekeeper #1 went on to explain the bottle of ammonium chloride that was observed in the lower C-hall shower room was used to clean toilets and it should not have been left in the shower room. Housekeeper #2 was interviewed on 8/1/2019 at 9:21 AM and she reported the shower door should not be propped open and the cleanser ammonium chloride should have been locked up and secured and not left in the shower room. An interview with Housekeeper #3 was conducted	F 689	All new housekeeping and nursing staff will be in-serviced on safe chemical storage, including the importance of keeping the shower room doors closed, by Staff Development Coordinator during orientation. Environmental services Director, Nurse Unit Supervisor, or Manager on Duty will audit shower rooms for proper chemical storage, including closed shower room doors, 5 times a week for one month, 3 times a week for one month, and 2 times a week for one month. Any improperly stored chemicals will be placed in proper storage upon discovery. Any open shower room doors will be closed at that time. Any trends in improper chemical storage, including shower room doors being left open, will be monitored at monthly Quality Assurance Performance Improvement meetings and addressed by the Interdisciplinary Team. The Environmental Services Director is responsible for this plan of correction.	

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F 689	Continued From page 12 on 8/1/2019 at 9:22 AM and he reported a nurse had asked for the cleanser and had not returned it to him. Housekeeper #3 was not certain when the nurse asked for the cleanser. The Unit C/D hall Manager (UM) #2 was interviewed on 8/1/2019 at 9:28 AM and she reported she had not noticed the lower C-hall shower room door was opened and she was not aware the cleanser ammonium chloride was in the shower room and not locked up. UM #2 went on to explain the nursing staff usually used sanitizing wipes to clean up spills and then would call housekeeping to disinfect the area and she was not certain why a nurse would have asked for the cleanser. The Director of Nurses (DON) was interviewed on 8/1/2019 at 4:38 PM and she reported the shower room doors should always be closed and the cleanser ammonium chloride should have been locked up to prevent accidental ingestion of the chemical by a confused resident. The DON went on to explain her expectation that all chemicals were locked up to prevent accidents. The Administrator was interviewed on 8/1/2019 at 4:53 PM and he reported he expected the chemicals were safely stored and that the facility had a safe environment. The Administrator went on to explain he felt there was a gap in staff education regarding the shower doors being closed and the storage of the chemicals.	F 689		
F 732 SS=C	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	F 732		8/27/19

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F 732	Continued From page 13 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. §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 staff interview and review of required posted nursing staffing sheets dated 7/25/19 through 7/31/19, the facility failed to post accurate	F 732	Facility failed to post accurate nurse staffing data due to staff education error.	

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F 732	Continued From page 14 staffing information as compared to the Daily Nursing Staff Schedule for 7 days of the 7 days reviewed (7/25/19 through 7/31/19) and failed to post accurate skilled nursing facility resident census for 7 of the 7 days reviewed. Findings included: Review of the Direct Care Nursing Staff Posting for 7/25/19 revealed there were 3 Nursing Assistants (NAs) on the 11:00 PM to 7:00 AM shift for the A Hall and B Hall (AB Hall) Skilled Nursing Facility (SNF) population for a total of 37.5 hours. Review of the CD Hall 11:00 PM to 7:00 AM shift revealed there were 2 NAs for a total of 22.5 hours. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Review of the Direct Care Nursing Staff Posting for 7/26/19 revealed there were 3 NAs on the 11:00 PM to 7:00 AM shift for AB Hall SNF population for a total of 30.0 hours. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Review of the Direct Care Nursing Staff Posting for 7/27/19 revealed there were 7 NAs and on the 3:00 PM to 11:00 PM shift for AB Hall SNF for 49.0 hours and one Medication Aide (Med Aide) for 8 hours for the total unlicensed nursing hours for the shift covering the SNF population of AB hall of 57.0 hours. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM.	F 732	All residents are potentially affected by this deficient practice. Posted nurse staffing sheet format was updated for ease of use, and to reflect the difference between skilled nursing care hours and assisted living nursing hours by Administrator on 7/31/19. Nurse scheduler, Unit Nurse Supervisors, and Charge Nurses responsible for updating posted nurse staffing will be in-serviced on locating accurate facility census by Staff Development Coordinator prior to beginning their next assigned shift. Nurse scheduler, Director of Nursing, and Nurse Supervisors were in-serviced on proper nursing staff postings by Administrator on 8/12/19. Director of Nursing, Administrator, or Weekend Manager will audit posted nurse staffing sheets 5 days a week for one month and 3 days a week for two months. Any inaccuracies in posted nurse staffing will be corrected at that time by Director of Nursing, Administrator, or Weekend Manager. Audit results will be monitored by Interdisciplinary Team at monthly Quality Assurance Performance Improvement meetings. Any trends in posted nurse staffing inaccuracies will be addressed by the Administrator or Director of Nursing at that time.	

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F 732	Continued From page 15 Review of the Direct Care Nursing Staff Posting for 7/28/19 revealed there were 7 NAs on the 7:00 AM to 3:00 PM shift for AB Hall SNF population and there were no total unlicensed nursing hours entered for the shift. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Review of the Direct Care Nursing Staff Posting for 7/29/19 revealed there were 3 NAs on the 11:00 PM to 7:00 AM shift for AB Hall SNF population for a total of 30.0 hours. Review of the CD Hall 3:00 PM to 11:00 PM shift revealed there were 3 NAs for a total of 30.0 hours. Review of the census for the dementia unit revealed a recorded census of 12 residents for Assisted Living (AL) and no recorded census for the SNF for 11:00 PM to 7:00 AM. Review of the Daily Assignment Sheet for 7/29/19 revealed the facility had posted 5 NAs to the CD Hall for the 3:00 PM to 11:00 PM shift for the SNF population. Further review revealed facility had posted 4 NAs on the 11:00 PM to 7:00 AM shift for the AB Hall and there were 3 NAs posted to the AB Hall for the SNF population. Next to the AB Hall assignment there was a note to send one NA to the CD Hall. Review of the Direct Care Nursing Staff Posting for 7/30/19 revealed there were 4 NAs on the 11:00 PM to 7:00 AM shift for AB Hall SNF population for a total of 30.0 hours. Review of the CD Hall 3:00 PM to 11:00 PM shift revealed there were 4 NAs for a total of 30.0 hours. Review of the CD Hall 11:00 PM to 7:00 AM shift revealed	F 732	The director of nursing is responsible for this plan of correction.	

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F 732	Continued From page 16	F 732		

there were 3 NAs for a total of 15.0 hours. Review of the dementia unit 3:00 PM to 11:00 PM shift revealed there were 5 NAs for a total of 37.5 hours. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM.

Review of the Daily Assignment Sheet for 7/30/19 revealed the facility had posted 4.5 NAs to the CD Hall for the 7:00 AM to 3:00 PM shift for the SNF population. Further review revealed facility had posted 4 NAs on the 3:00 PM to 11:00 PM shift for the CD Hall and there were 5 NAs posted to the dementia unit for the SNF population. However, there was a note next to the names for the dementia unit documenting one NA was to be sent to the CD Hall, which would have resulted in there having been 5 NAs on the CD unit and 4 NAs on the dementia unit. For the 11:00 PM to 7:00 AM the facility had posted 5 NAs for the AB unit and 3 NAs for the CD unit.

Review of the Direct Care Nursing Staff Posting for 7/31/19 revealed there were 3 NAs on the 11:00 PM to 7:00 AM shift for AB Hall SNF population for a total of 30.0 hours. Review of the census for the dementia unit revealed a recorded census of 24 SNF residents for 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM.

Review of the Daily Assignment Sheet for 7/31/19 revealed the facility had posted 3 NAs to the AB Hall for the 11:00 PM to 7:00 AM shift for the SNF population.

Further review of all 7 Direct Care Nursing Staff Posting forms, 7/25/19 through 8/31/19, recorded

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census, revealed zero days of seven with changes to the posted census from shift to shift which would reflect admissions and discharges.

An interview was conducted with the Scheduler on 8/1/19 at 11:08 AM. The Scheduler stated she was responsible for filling out the Direct Care Nursing Staff Posting forms and was in charge of staffing. She stated she filled out the staffing numbers and census on the form then posted the form or forms. She stated she would make adjustments on the forms as needed for first and second shift while she was at the facility and she believed the nurse on third shift would then make modifications to the forms as needed. She also stated she would post the forms for the weekend, Friday, Saturday, and Sunday, Friday afternoon and the nurses would make changes on the form as needed. The scheduler reviewed the Direct Care Nursing Staff Posting forms and compared it to the Daily Assignment Sheet and discovered discrepancies for staffing for the following days: 7/25/19, 7/26/19, 7/27/19, 7/28/19, 7/29/19, 7/30/19, and 7/31/19. Further review by the Scheduler revealed the census number had not been changed during the shift to reflect admissions and discharges and the census for the dementia unit was not separated for six of seven days, 7/25/19, 7/26/19, 7/27/19, 7/28/19, 7/30/19, and 7/31/19, to accurately reflect the census of SNF residents, verses Assisted Living (AL) residents. Census for 7/29/19 had no recorded census for SNF residents for 11:00 PM to 7:00 AM. The Scheduler stated she was new and was not familiar with how many residents in the dementia unit were in SNF beds and how many were in AL beds nor was she aware of how to differentiate staffing time for SNF residents, verses AL residents on the Direct Care Nursing

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F 732	Continued From page 18 Staff Posting form. An interview was conducted with the Administrator on 8/1/19 at 1:12 PM. The Administrator stated he felt he could improve the Direct Care Nursing Staff Posting form. The Administrator further stated it was important the form be updated timely to reflect census, including admissions and discharges. The Administrator stated he would develop a more streamlined census sheet and would involve other department heads in assisting with the updating of the sheets regarding both staffing and census. Regarding the dementia unit and the SNF residents verses the AL residents he stated he would provide education to the staff involved with the form of how to record staffing hours to reflect the different skill levels. The Administrator further stated he would initiate audits to make sure the forms were accurate, correct, and adjustments had been made to the staffing form to ensure the interventions put into place were successful to meet his expectations that the staffing form accurate and updated timely. it was her expectation for the Daily Nursing Hours for Healthcare Centers Form to be updated and accurate through the day. The Administrator further stated she expected the weekend supervisor to update the form through the weekend and during the 11:00 PM to 7:00 AM shift the nurse could update the form.	F 732		