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	345268	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 08/04/2019 through 08/07/2019. The facility was found in compliance withthe requirementCFR 483.73, Emergency Preparedness. Event ID # 6P9611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/04/2019 through 08/07/2019. Event ID # 6P9611. [x] 1 of the 14 complaint allegation(s) were substantiated but did not result in a deficiency.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, staff interviews and resident interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 5 residents reviewed for MDS accuracy (Resident # 57 and Resident # 95) reviewed for skin conditions (MDS section M) and Residents # 38, 42 and 62) reviewed for bathing (MDS section G). Findings included: 1. Resident # 57 was readmitted to the facility on 05/26/2019 with diagnoses that included spinal cord injury, neurogenic bowel, neuromuscular bladder, cramps, spasms, muscle weakness and paraplegia.	F 641	*Resident#57□s Minimum Data Set was modified August 7, 2019 to reflect three stage four pressure ulcers for the Minimum Data Set dated 7/1/19. The modified Minimum Data Set also reflects that Resident#57 utilizes a pressure reduction chair cushion. Resident#38 is care planned for shower refusals and Resident#42 for exhibiting behavior indicative of not desiring a shower such as physical and verbal aggression. Resident#38□s Minimum Data Set was modified on August 28, 2019 to reflect one out of two showers she received during the lookback period. Resident#42□s Minimum Data Set dated 6/10/19 does	9/4/19

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

Electronically Signed | 08/30/2019

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F 641	Continued From page 1 A review of a quarterly Minimum Data Set (MDS) dated 07/01/2019 coded Resident # 57 as cognitively intact, frequently incontinent of bladder and always incontinent of bowel. Resident # 57 was coded to have 2 stage 4 pressure ulcers that were present on admission. Resident # 57 had a pressure reduction mattress on his bed, received nutrition and hydration for pressure ulcer healing and received non-surgical dressings with or without topical medication to areas other than his feet Care plans reviewed for Resident # 57 updated on 07/01/2019 in part that Resident # 57 had impaired skin integrity related to paraplegia and the goal was the Resident # 57's skin would be free of redness, blisters and discoloration through the next review. Interventions included in part that medications were to be administered as ordered, treatments would be provided as ordered, Resident # 57 would be maintained on an air mattress as ordered, Resident # 57 would be turned and repositioned during care rounds and as needed as tolerated and that Vohra wound Doctor (MD) would consult Resident # 57 as needed (prn). A Vohra Wound Physician (MD) note dated 06/25/2019 included in part that Resident # 57 had a stage 4 pressure ulcer of the right lateral ankle, a stage 4 pressure ulcer of the right posterior foot and a stage 4 pressure ulcer of the right buttock. A review of a form titled Weekly Pressure Ulcer Review dated 06/27/2019 was provided by the facility wound nurse. The form revealed that Resident # 57 had a stage 4 pressure ulcer of the	F 641	reflect total dependence for showers vs did not occur. Resident#62 is care planned for refusing showers and also that she prefers to wash up independently. Resident#95□s Minimum Data Set was modified August 7, 2019 to reflect a wound infection. *Other residents with pressure ulcers that reside in the facility had their Minimum Data Set audited by the Director of Nursing on 8/28/19 and reconciled against the weekly wound report to ensure the coding is accurate. Other residents who utilize pressure reduction chair cushions had their Minimum Data Set reviewed and reconciled to ensure accurate coding by the Director of Nursing on 8/28/19. Minimum Data Sets were also reviewed for residents who reside in the facility currently to review those being coded that showers and bathing did not occur. The Minimum Data Set coding was reconciled against the clinical documentation and staff interviews. This review was done by the Director of Nursing on 9/3/19. Other residents with wound infections had their Minimum Data Sets audited to ensure this was captured on the Minimum Data Set. This was also done by the Director of Nursing on 9/3/19. If coding errors were identified with any of the above clinical areas, the Director of Nursing ensured the Minimum Data Set Nurses updated the documentation. *Both Minimum Data Set nurses were reeducated by the Administrator on 9/3/19 to ensure accurate coding of pressure	

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F 641	Continued From page 2 right posterior foot, a stage 4 pressure ulcer of the right buttock and a stage 4 pressure ulcer of the right lateral ankle. An observation and interview of Resident # 57 on 08/04/2019 at 1:12 PM revealed Resident # 57 alert and oriented, seated in a wheel chair in the hall outside of his room. Resident # 57 revealed that he did have a few pressure ulcers and that he did have an air mattress on his bed. Resident # 57 was observed with a pressure reduction cushion in the seat of his wheel chair. On 08/06/2019 at 11:47 AM an interview was conducted with the facility wound nurse. The wound nurse revealed that she did not code any section on the MDS and that on review of wound documentation of Resident # 57 during the review period for the MDS dated 07/01/2019, Resident # 57 did have 3 stage 4 pressure areas and that was documented in the MD notes and on the Weekly Pressure Ulcer Review form that she provided to the MDS nurse weekly. An interview with the MDS nurse conducted on 08/07/2019 at 11:33 AM revealed that she must have miscoded the MDS dated 07/01/219 for Resident # 57 because when she reviewed the wound documentation during the look back (review) period for the MDS dated from 06/25/2019 through 07/01/2019 she was able to confirm that Resident # 57 did have 3 stage 4 pressure ulcers. The MDS nurse also revealed that she did know that Resident # 57 did have a pressure ulcer reduction cushion in his wheel chair and that the wheel chair cushion should have been coded on the same MDS because she had observed it in place. The MDS nurse revealed that she had made an error and forgot to	F 641	ulcers, wound infections and pressure reduction chair cushions when completing an Minimum Data Set by using the weekly wound report, via discussions with the wound care nurse, visualization of resident and reviewing clinical documentation. The Minimum Data Set nurses were also reeducated by the Administrator on ensuring they interview the staff regarding showering as well as reviewing the clinical documentation. This was done 9/3/19. Nursing staff were reeducated on the process of shower/bathing refusals. This education includes what actions to take if a resident refuses a shower to include documentation/notification. This was done by the Registered Nurse Administrative Supervisor/designee from 8/30/19-9/3/19. *An audit will be done weekly by the Director of Nursing/designee to ensure accurate coding of the Minimum Data Set to include the following: number and stages of wounds a resident has, pressure reduction chair cushions, coding of showers and proper coding of wound infections. The audit will include interviewing the Minimum Data Set nurses to ensure they discussed the resident with the direct care staff. These audits will be done weekly for four weeks then monthly for two months. Audit results will be taken to the Quality Assurance and Performance Improvement Committee who will determine when auditing is no longer necessary.	

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F 641	Continued From page 3	F 641		

code the pressure reduction chair cushion.

On 08/07/2019 at 2:38 PM an interview was conducted with the facility administrator. The administrator revealed that she expected that MDSs be coded to reflect each resident clinically.

3. Resident #38 was readmitted to the facility on 2/25/2019 with diagnoses to include diabetes, dementia and chronic pain. The most recent annual Minimum Data Set (MDS) dated 6/4/2019 assessed Resident #38 to be severely cognitively impaired and did not reject care during the look back period.

A review of Resident #38 ' s medical chart revealed no documentation regarding refusal of bathing for June and July 2019.

An interview was conducted with nursing assistant (NA) #2 on 8/6/2019 at 3:14 PM. NA #2 reported Resident #38 refused showers. NA #2 reported staff were supposed to report refusals to the nurse and document the refusal on a shower sheet.

NA #3 was interviewed on 8/6/2019 at 3:28 PM and she reported Resident #38 refused care and a nurse was supposed to be notified.

Nurse #2 was interviewed on 8/7/2019 at 11:18 AM and she reported Resident #38 refused care and nursing staff were supposed to document the refusals.

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The Director of Nurses (DON) was interviewed on 8/7/2019 at 2:21 PM and she reported the NA staff were not documenting shower refusals and nurse staff were not checking the NA documentation. The DON reported her expectation was the NA staff documented care that matched the care that was provided for the resident.

The MDS Nurse was interviewed on 8/6/2019 at 11:56 AM. She stated she was unaware that Resident #38 had refused any care including showers. She reported Resident # 38 did not have any type of bathing assistance or refusals of care documented in the look-back period for the quarterly MDS dated 6/4/2019. The MDS nurse explained when Resident #38 ' s quarterly MDS of 06/04/19 was completed she only reviewed the resident ' s record for information but did not interview staff about the information on the MDS to ensure it was accurate.

4. Resident #42 was readmitted to the facility on 9/26/2017 with diagnoses to include diabetes, dementia and dysphagia. The most recent quarterly Minimum Data Set (MDS) dated 6/10/2019 assessed Resident #42 to be severely cognitively impaired and did not reject care. The MDS documented bathing assistance during the look back period did not occur for Resident #42.

A review of Resident #42 ' s medical chart revealed no documentation regarding refusal of bathing for June or July 2019.

An interview was conducted with nursing assistant (NA) #2 on 8/6/2019 at 3:14 PM and she reported Resident #42 refused showers. NA #2 reported staff were supposed to report

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F 641	Continued From page 5	F 641		

refusals to the nurse and document the refusal on a shower sheet.

NA #3 was interviewed on 8/6/2019 at 3:28 PM and she reported Resident #42 refused care and a nurse was supposed to be notified.

Nurse #2 was interviewed on 8/7/2019 at 11:18 AM and she reported Resident #42 refused care and nursing staff were supposed to document the refusals.

The Director of Nurses (DON) was interviewed on 8/7/2019 at 2:21 PM and she reported the NA staff have not been documenting shower refusals and nurse staff were not checking the NA documentation. The DON reported her expectation was the NA staff documented care that matched the care that was provided for the resident.

The MDS Nurse was interviewed on 8/6/2019 at 11:56 AM. She stated she was unaware that Resident #42 had refused any care including showers. She reported Resident # 42 did not have any type of bathing assistance or refusals of care documented in the look-back period for the quarterly MDS dated 6/10/2019. The MDS nurse explained when Resident #42 ' s quarterly MDS of 06/10/19 was completed she only reviewed the resident ' s record for information but did not interview staff about the information on the MDS to ensure it was accurate.

5. Resident #62 was readmitted to the facility on 10/16/2018 with diagnoses to include high blood pressure, dementia and muscle weakness. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/22/2019 assessed Resident

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#62 to be severely cognitively impaired and did not reject care. The MDS documented bathing assistance during the look back period did not occur for Resident #62.

Resident #62 ' s medical care was reviewed and no revealed no documentation regarding refusal of care for June or July 2019.

The MDS nurse was interviewed on 8/6/2019 at 11:56 AM and she reported Resident # 62 did not have any type of bathing assistance documented in the look-back period for the quarterly MDS dated 7/22/2019 and she documented that bathing had not occurred for Resident #62. The MDS nurse further explained the charting system was set up to document only showers and not if alternate bathing was given to the resident. The MDS reported she reviewed records for information regarding bathing assistance but had not interviewed staff about the type of bathing assistance that was given to Resident #62.

An interview was conducted with nursing assistant (NA) #2 on 8/6/2019 at 3:14 PM and she reported Resident #62 rarely refused showers and she very much enjoyed her showers. NA #2 reported staff were supposed to report refusals to the nurse and document the refusal on a shower sheet.

NA #3 was interviewed on 8/6/2019 at 3:28 PM and she reported Resident #62 did not refuse showers.

The Director of Nurses (DON) was interviewed on 8/7/2019 at 2:21 PM and she reported the NA staff have not been documenting shower refusals and nurse staff were not checking the NA

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documentation. The DON reported her expectation was the NA staff documented care that matched the care that was provided for the resident.
2. Resident #95 was most recently readmitted to the facility on 8/27/19. The resident's cumulative diagnoses included: Left above the knee amputation, diabetes, lymphedema, and an open wound to the left lower leg.

A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/19 revealed Resident #95 was coded as having been cognitively intact, received application of ointments/medications/nonsurgical dressings but not to the feet, received antibiotic medication during each of the 7 days of the assessment period, and the resident was not coded as having had a wound infection (other than to the foot).

Review of Resident #95's Care plan revealed his care plan had been updated on 7/16/19 with a care plan Focus of the resident having had a wound infection to the left lower extremity and was on antibiotic therapy. Further review revealed a Focus, updated on 7/16/19, of the resident having been at risk for complications related to a wound infection to the left lower extremity. The goal of the focus was for the resident to be free from complications related to the infection through the next review date.

Review of a lab report discovered in the Electronic Medical Record (EMR) Resident #95 with a draw date of 7/9/19 and a result and reported date of 7/13/19 revealed the resident had a culture from a wound on the left lower leg which showed positive results of infectious

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F 641	Continued From page 8 bacteria from the wound. The wound report was documented as having been faxed to two Nurse Practitioners, one on 7/13/19 and the other on 7/14/19, and appropriate antibiotic treatment for the infection was prescribed. During an interview with the MDS nurse conducted on 8/6/19 at 11:56 AM she stated she was responsible for completing the section of the MDS assessment for diagnoses and she had completed Resident #95's MDS quarterly assessment with an ARD of 7/16/19. The MDS Coordinator stated she had coded the resident as having had received antibiotics for each day of the assessment period. The MDS Coordinator stated the resident was receiving antibiotics for an infection to his left lower leg, but not his foot. The MDS Coordinator stated she should have coded the resident as having had a diagnosis of a wound infection in the 7/16/19 quarterly MDS assessment. The MDS Coordinator further stated she would submit a modification to correct the inaccurate coding and would supply the validation report after the MDS assessment was submitted. During an interview conducted on 8/7/19 at 2:14 PM the administrator stated it was her expectation for the MDS assessments be completed accurately so as to reflect the clinical status of each resident.	F 641		
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 must post the following information on a daily basis:	F 732		9/4/19

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F 732	Continued From page 9 (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 staffing information as compared to the Daily Nursing Staff Schedule for 7 days of the 7 days	F 732	*Including the Home for the Aged hours worked by staff on the Posting Daily Nurse Staffing sheet, which was incorrect, affected all residents throughout the facility.	

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F 732	Continued From page 10 reviewed (7/25/19 through 7/31/19). Findings included: Review of the Posted Daily Nurse Staffing for 7/25/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 112 hours for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) and a total of 246.5 hours for Nursing Assistants (NAs). Review of the Daily Assignment for 7/25/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611. Review of the Posted Daily Nurse Staffing for 7/26/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 112 hours for RNs and LPNs and a total of 217.5 hours for NAs. Review of the Daily Assignment for 7/26/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM. From 3:00 PM to 11:00 PM the NA assignment including the 100 Hall was adjusted to 100 Hall/room 611.	F 732	*The Posting Daily Nurse Staffing sheet no longer reflects hours worked by staff on the Home for the Aged unit during all three shifts. *The Administrator is now aware that the Posted Daily Nurse Staffing form cannot include Home for the Aged hours worked by direct care staff. The Administrator then reeducated the Director of Nursing on 8/29/19 who then reeducated Registered Nurse Administrative Supervisor and Scheduler on 8/29/19 that the Posted Daily Nurse Staffing form cannot reflect direct care workers hours on the Home for the Aged hall. Our weekend Registered Nurse House Supervisor and other administrative nurses were reeducated by the Director of Nursing on the expectations for the Posted Daily Nurse Staffing form to include not documenting Home for the Aged direct care workers hours. This occurred from 8/29/19-9/3/19. *An audit of the Posted Daily Nurse Staffing form to ensure it does not contain Home for the Aged hours worked by direct care staff will be done by the Administrator/designee weekly for four weeks then monthly for two months. The Administrator will be responsible for this plan of correction. Audit results will be taken to the Quality Assurance and Performance Improvement Committee who will determine when auditing is no longer necessary.	

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From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

Review of the Posted Daily Nurse Staffing for 7/27/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 96 hours for RNs and LPNs and a total of 195 hours for NAs.

Review of the Daily Assignment for 7/27/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

Review of the Posted Daily Nurse Staffing for 7/28/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 96 hours for RNs and LPNs and a total of 195 hours for NAs.

Review of the Daily Assignment for 7/28/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

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F 732	Continued From page 12	F 732		

Review of the Posted Daily Nurse Staffing for 7/29/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 96 hours for RNs and LPNs and a total of 205 hours for NAs.

Review of the Daily Assignment for 7/29/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM. From 3:00 PM to 11:00 PM the NA assignment including the 100 Hall was adjusted to 100 Hall/room 611. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

Review of the Posted Daily Nurse Staffing for 7/30/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 112 hours for RNs and LPNs and a total of 195 hours for NAs.

Review of the Daily Assignment for 7/30/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

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F 732	Continued From page 13	F 732		

Review of the Posted Daily Nurse Staffing for 7/31/19 revealed the following was written next to the census, Census does not include residents on the 100 Hall. Further review revealed there was a total of 104 hours for RNs and LPNs and a total of 195 hours for NAs.

Review of the Daily Assignment for 7/31/19 revealed there was a nurse (LPN or RN) assigned to the 100 Hall/300 Hall/rooms 608-611 assignment from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. Further review revealed an NA assigned to the 100 Hall assignment from 7:00 AM to 3:00 PM. From 3:00 PM to 11:00 PM the NA assignment including the 100 Hall was adjusted to 100 Hall/room 611. From 11:00 PM to 7:00 AM the NA assignment including the 100 Hall was adjusted to 100 Hall/300 Hall/rooms 610-611.

During an interview conducted on 8/7/19 at 7:39 AM with Nurse #3 she stated the beds on the wall hall were the Home for the Aged (HA) beds. She further stated the beds were for private pay residents and were not certified for Medicaid or Medicare residents.

During an interview conducted on 8/7/19 a t 12:08 PM with the Scheduler she stated if a staff member was assigned to the 100 Hall, where the HA beds were, they still aided residents of other halls in certified beds. She further stated the assistance may include help with transfers, during meal time, or other ADL care residents not on the 100 Hall may require. She stated she was aware the residents from the 100 Hall were not counted as part of the census but had not realized the need to separate staffing time provided to the residents on the 100 Hall in the HA beds. The

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F 732	Continued From page 14 Scheduler stated the total hours on the Posted Daily Nurse Staffing sheet did include hours provided to residents on the 100 Hall in HA beds. During an interview conducted with the Administrator on 8/7/19 at 2:14 PM she stated her expectation was for staffing numbers to be displayed accurately.	F 732		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 12.0% (3 errors out of 25 opportunities) (Resident #44, Resident #251, and Resident #55). Findings included: 1. Resident #44's physician orders were reviewed, and he was prescribed one drop of Artificial Tears Solution 0.4% (Hypromellose) in both eyes four times a day dated 12/30/16. The electronic Medication Administration Record (eMAR) was reviewed on 8/5/19 at 4:40 PM and Artificial Tears Solution 0.4% was documented as having been administered at 4:00 PM on 8/5/2019. A medication administration was observed on	F 759	*Resident#44 did receive his Artificial Tear Solution 0.4% eye drops when the surveyor made Nurse #4 aware that the drops were not administered. Resident#251 did have her Acetaminophen order changed from two tablets to one 500mg by the physician assistant. A medication error report was completed to reflect the second Acetaminophen not being given. Resident#55 did receive the second 2mg tablet of Glimepiride when the surveyor made Nurse #5 aware that the second dose had not been given. *No other residents were identified as not having received eye drops during the medication pass observation. No other residents were identified as having Acetaminophen discrepancies. No other	9/4/19

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F 759	Continued From page 15 8/5/19 at 4:14 PM with Nurse #4. The Artificial Tears Solution 0.4% eye drops were not administered to Resident #44. Nurse #4 was interviewed on 8/5/19 at 4:40 PM. She stated she had not administered the Artificial Tears Solution 0.4% eye drops to the resident. The nurse was then observed to have removed the Artificial Tears Solution 0.4% eye drops from her cart and administer them to the resident. The nurse stated she had signed of as having administered the eye drops but had not administered them earlier during the medication administration observation. The nurse further stated, she had thought she had administered them before and that is why she had signed them off as administered but had not administered them. The Director of Nursing (DON) was interviewed on 8/7/19 at 12:44 PM. She stated it was her expectation for the nurses to follow the medication policy and procedures. The Administrator was interviewed on 8/7/19 at 2:14 PM and she stated it was her expectation for the nurses to follow the physician's orders when administering medications. 2. Resident #251's physician orders were reviewed, and she was prescribed two 500 milligram (mg) Acetaminophen tablets every 8 hours as needed for pain, fever for 2 days, dated 8/6/19. The eMAR was reviewed on 8/6/19 at 2:07 PM and the Acetaminophen was not documented as having been administered since prescribed on 8/6/19. A medication administration pass was observed	F 759	residents were identified as not having received a second tablet of Glimepiride. *Education was done with licensed nursing staff on all three shifts regarding the expectation that documentation in the Medication Administration Record should be not done until the medication has been administered. This was done by the Director of Nursing and Registered Nurse Administrative Nurse. The nurses were also reeducated that medications must be given according to physician orders. This education was done by the Director of Nursing and Registered Nurse Administrative Nurse from 8/29/19-9/3/19. Nurse #4 and #5 were reeducated on the Six Rights of Medication Administration. A Medication Administration Skills Checklist was completed with Nurse #4 and #5. The checklists and reeducation with the two nurses was done by the Director of Nursing on 9/3/19 and 9/4/19. *Director of Nursing/designee will conduct a Medication Administration Skills Checklist with one nurse a week for four weeks then with one nurse monthly for two months to ensure medication is being administered according to physician orders. Audit results will be taken to the Quality Assurance and Performance Improvement Committee who will determine when auditing is no longer necessary. The Director of Nursing is responsible for the plan of correction.	

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F 759	Continued From page 16	F 759		

on 8/6/19 at 8:43 AM with Nurse #5. Nurse #5 was observed administering one 500 mg Acetaminophen to Resident #251. The resident was observed to accept the one 500 mg Acetaminophen pill and did not refuse nor request a second 500 mg Acetaminophen pill. The nurse was not observed to offer a second 500 mg Acetaminophen pill to the resident.

Nurse #5 was interviewed on 8/6/19 at 2:07 PM. She stated the standing order was for two 500 mg Acetaminophen pills, but the Clinical Coordinator was supposed have put in an order for Resident #251 to receive one 500 mg Acetaminophen pill. The nurse stated the resident can request to have one of the 500 mg Acetaminophen pills, but you could not administer more than two, what was prescribed. The nurse stated she would contact the Physician's Assistant (PA) to obtain an order to administer 1-2 500 mg Acetaminophen pills. The nurse stated she had not signed off as having had administered the medication and had not entered a nurses' note regarding having had administered the Acetaminophen.

The Director of Nursing (DON) was interviewed on 8/7/19 at 12:44 PM. She stated it was her expectation for the nurses to follow the medication policy and procedures.

The Administrator was interviewed on 8/7/19 at 2:14 PM and she stated it was her expectation for the nurses to follow the physician's orders when administering medications.

3. Resident #55's physician orders were reviewed, and she was prescribed 4 mg Glimepiride once daily to be administered orally for diabetes mellitus, dated 7/24/19. The eMAR

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F 759	Continued From page 17	F 759		

was reviewed on 8/6/19 at 2:07 PM and the Glimepiride 4 mg was documented as having been administered at 8:00 AM on 8/6/19.

A medication administration pass was observed on 8/6/19 at 8:43 AM with Nurse #5. Nurse #5 was observed administering one 2 mg Glimepiride tablet to Resident #55.

Nurse #5 was interviewed on 8/6/19 at 2:07 PM. She had only given Resident #55 one Glimepiride, but she should have given her more than one. The nurse checked the medication and stated she had only administered the resident one 2 mg Glimepiride, but she should have administered two 2 mg Glimepiride pills for a total of 4 mg of Glimepiride. The nurse stated she does typically review the eMAR and then verify the medication she is administering but she had not at that time. The nurse stated she would administer the second 2 mg Glimepiride pill immediately. The nurse was observed to proceed, prepare the second 2 mg Glimepiride pill, and take it to the resident's room to administer it to the resident.

An interview was conducted on 8/7/19 at 10:02 AM with the resident's Nurse Practitioner (NP). The NP stated the resident needed to receive the full dose, 4 mg, of the prescribed Glimepiride for her diabetes mellitus. The NP further stated if the resident did not receive her full does of Glimepiride the resident was at an increased risk for elevated blood sugar levels. The NP stated it was her expectation for residents to receive the medications which were prescribed for them.

The Director of Nursing (DON) was interviewed on 8/7/19 at 12:44 PM. She stated it was her

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F 759	Continued From page 18 expectation for the nurses to follow the medication policy and procedures. The Administrator was interviewed on 8/7/19 at 2:14 PM and she stated it was her expectation for the nurses to follow the physician's orders when administering medications.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 761	*Nurse #4 removed the bottle of	9/4/19

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F 761	Continued From page 19 facility failed to secure a stock bottle of simethicone and failed to secure a bottle of artificial tears (eye drops) for one (200 hall) of four medications carts. Findings include: On 8/5/19 at 4:14 PM Nurse #4 was observed preparing medications. The nurse locked the medication cart, leaving a bottle of simethicone 125 milligram (mg) (extra strength gas relief) tablets and a box containing a bottle of artificial tears 0.4% (eye drops) on top of the cart. The nurse stated she had to retrieve additional medications for a resident from the med room. The nurse proceeded to leave the hall containing the medication cart. At approximately 4:20 PM on 8/5/19 the nurse was observed to have locked the medication cart, leaving a bottle of simethicone 125 mg (extra strength gas relief) tablets and a box containing a bottle of artificial tears 0.4% (eye drops) on top of the cart. The nurse then proceeded to go into a resident room where the medication cart was out of the direct site of the nurse. At approximately 4:40 PM on 8/5/19 the nurse was observed to have been returning to her cart and the bottle of simethicone 125 milligram (mg) (extra strength gas relief) tablets were still observed on top of the medication cart. An interview with Nurse #4 was conducted on 8/5/19 at 4:41 PM. The nurse stated she should not have left the bottle of simethicone 125 milligram (mg) (extra strength gas relief) tablets on top of the medication cart unattended, nor the bottle of artificial tears (eye drops). The nurse proceeded to pick up the bottle and the tablets	F 761	simethicone tables from the top of the cart and secured them properly. The Artificial Tears were placed back in the medication cart by Nurse #4. *When it was brought to our attention that the nurse did not secure the medications, our Clinical Nurse Consultant conducted an audit of the other facility medication carts and no other issues were noted regarding storage of drugs and biologicals during medication pass observations. *Nurse #4 was reeducated on medication storage expectations by the Assistant Director of Nursing on 9/3/19. Other licensed staff on all three shifts were reeducated using our pharmacy storage of medication policy. This training was done by the Director of Nursing/designee from 8/29/19-9/3/19. *Director of Nursing/designee will conduct a Medication Administration Skills Checklist with one nurse a week for four weeks then one nurse monthly for two months to ensure drugs and biologicals are being stored appropriately. Audit results will be taken to the Quality Assurance and Performance Improvement Committee who will determine when auditing is no longer necessary. The Director of Nursing is responsible for the plan of correction.	

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F 761	Continued From page 20 were heard rattling inside of the bottle. The nurse stated she had put the artificial tears (eye drops) away in the medication cart after she had returned from the resident's room. The nurse further stated she had meant to put the simethicone tablets away because they did not belong on the cart. The nurse was observed to lock the medication cart and took the simethicone tablets with her down the hall. An interview with the Director of Nursing (DON) was conducted on 8/7/19 at 12:44 PM. The DON stated medications should not be left unattended. During an interview conducted on 8/7/19 at 2:14 PM the Administrator stated it was her expectation for nurses to complete their medication pass in compliance with the facility policies and procedures regarding the medication pass and medication storage.	F 761		
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 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.	F 812		9/4/19

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F 812	Continued From page 21 §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 observations and staff interviews, the facility failed to remove expired food items from the refrigerator units and date opened food items stored in refrigeration and freezer units and failed to clean 1 of 2 ice machines in nutrition rooms. This had the potential to affect 100 of 101 residents in the facility. Findings included: 1. Observations of foods and beverages stored in the kitchen ' s refrigeration and freezer storage revealed the following: a. Observations on 8/4/19 at 11:19 AM of food stored inside a three-door refrigerator in the kitchen revealed a container labeled "biscuit gravy 7/4/19" and an open bag of frozen vegetable without a date when the package was opened. The biscuit gravy had condensation of water was noted within the container. b. Observations of the walk-in cooler on 8/4/2019 at 11:25 AM revealed an opened gallon of orange juice with a date open of 7/16/2019 and an expiration date of 8/1/2019, and an open and undated bag of lettuce with wilted and brown leaves. c. Observations of the kitchen ' s walk-in freezer on 08/04/19 at 11:30 AM revealed a bag of opened frozen unbaked cookies and there was no date when the package was opened.	F 812	*The biscuit gravy that was dated 7/4/19, the open bag of frozen vegetables without a date, the gallon of orange juice with an expiration date of 8/1/19, bag of lettuce, bag of unbaked frozen cookies was discarded by Dietary Supervisor. The ice machine in the nutrition room on the rehabilitation unit was deep cleaned on August 7, 2019 by the Director of Maintenance. *No other food items were identified to be of concern in the kitchen. The ice machine in the front nourishment room was inspected by the Director of Maintenance on August 7, 2019 and no other black splotches or areas of concern were noted. The kitchen staff on duty on August 5, 2019 were reeducated on food storage expectations by the Regional Dietician. *Education of proper food preparation and handling is being completed by the Dietary Supervisor with the kitchen staff. The kitchen staff, facility managers, and activity staff were reeducated that no food or drinks can be brought into the facility dietary department. This education was done by the Dietary Supervisor and Administrator. The Maintenance Director and Maintenance Assistant were reeducated by the Administrator on the	

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F 812	Continued From page 22 Cook #1 was interviewed on 8/4/2019 at 11:19 AM and she reported she thought the biscuit gravy had been misdated. Cook #1 further explained she did not know why the gallon of orange juice was in the kitchen ' s walk-in cooler. The Dietary Supervisor (DS) was interviewed on 8/6/2019 at 11:28 AM and she reported Cook #1 had put the bag of frozen vegetables into the refrigerator just prior to the observation and had been in the process of cooking the vegetables for the noon meal on 8/4/2019. The DS further reported that biscuit gravy was made daily and she thought the container of biscuit gravy found in the three-door cooler had been misdated 7/4/2019. The DS explained the kitchen did not use 1-gallon jugs of orange juice and thought the juice was from an activity and had been placed in the walk-in cooler on accident. The DS concluded by reporting she checked the stock in the refrigerators, coolers and freezer every Monday morning and the kitchen stock staff member would rotate and date, and every cook should check the refrigerators and the coolers every day for expired and undated food. The Administrator was interviewed on 8/7/2019 at 2:53 PM and she reported it was her expectation the food in the refrigerators, coolers and freezer were labeled and dated appropriately. 2. The ice machine in the nutrition room on the rehabilitation unit was observed on 8/7/2019 at 12:50 PM and black splotches were noted on the plastic tubing inside the ice machine. The maintenance supervisor (MS) was observed rubbing the black splotches off the tubing with his	F 812	expectation that the ice machines are to be cleaned and sanitized properly. The ice machines will be cleaned by the Maintenance Director/designee according to manufacturers guidelines and our ice machine cleaning procedure. Record of ice machine cleaning will be kept by the Maintenance Director by using an ice machine cleaning log. *An audit of the Dietary Department s refrigerators and freezers will be done by the Administrator/designee weekly for four weeks then monthly for two months to ensure there is no food items that are not dated and there is no expired food present. The ice machines will be audited for proper sanitation by the Administrator/designee weekly for four weeks then monthly for two months. Results of these audits will be taken to the Quality Assurance and Performance Improvement Committee who will determine when auditing is no longer necessary. The Administrator is responsible for this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 23 fingers. The MS was interviewed on 8/7/2019 at 12:50 PM and he reported the black splotches were mildew. He reported monthly cleaning of equipment occurred on the 1st Thursday of each month and he did not have a record of the cleaning that had been completed in the past. The Administrator was interviewed on 8/7/2019 at 2:53 PM and she reported it was her expectation the ice machines were to be cleaned and sanitized. The Administrator reported a cleaning log would be developed to document the cleaning of equipment.	F 812		