STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345160	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

(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/complaint survey was conducted on 9/22/19 through 9/26/19. The facility was in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# RQ9W11.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint investigation survey was conducted on 9/22/19 through 9/26/19, and 1 of 6 complaint allegations was substantiated with deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		10/18/19

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

Electronically Signed | 10/17/2019

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain privacy for 1 of 1 residents observed for catheter care by not covering their indwelling urinary catheter drainage bag while the resident was in bed (Resident #43). Findings included: Resident #43 was admitted to the facility on 06/08/18. Diagnoses included, in part, urinary retention and benign prostate hypertrophy (enlarged prostate). The quarterly Minimum Data Set assessment dated 06/12/19 indicated Resident #43 was severely cognitively impaired. Resident #43 was not coded as having an indwelling urinary catheter during the assessment period. The medical record revealed there was a physician ' s order written on 09/15/19 to change	F 550	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: Resident #43 had a privacy bag placed over catheter drainage bag on 09/24/2019	

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F 550	Continued From page 2 the indwelling urinary catheter as needed for occlusion, leakage and symptomatic infection, secure the catheter tubing with a leg strap and attach the receptacle (urinary catheter drainage bag) in a privacy bag and keep lower than kidneys. An observation of Resident #43 on 09/22/19 at 2:19 PM revealed the resident ' s indwelling urinary catheter drainage bag was not covered with a privacy bag while he was in his bed. The urinary catheter drainage bag was visible from the door and hallway while looking into Resident #43 ' s room. An observation of Resident #43 on 09/23/19 at 3:00 PM revealed the resident ' s indwelling urinary catheter drainage bag was not covered with a privacy bag while he was in his bed. The urinary catheter drainage bag was visible from the door and hallway while looking into Resident #43 ' s room. An observation of catheter care was conducted on 09/24/19 at 2:40 PM with Nursing Assistant (NA) #3 and NA/Household Coordinator (HHC) #4. NA #3 transferred Resident #43 from the dining room back to the resident ' s room while sitting in his wheelchair and the urinary catheter drainage bag was noted to have a privacy cover at this time. NA #3 positioned the resident next to the bed and proceeded to transfer the resident to the bed. NA/HHC #4 removed the urinary catheter drainage bag from the privacy bag on the wheelchair and held it while the resident was transferred to the bed by NA #3. The resident remained in bed and NA/HHC #4 hung the urinary catheter drainage bag on the side of the bed. NA/HHC #4 did not put the urinary catheter	F 550	while in bed. 2) Interventions for residents identified as having potential to be affected: Audit of residents with indwelling catheter and drainage bags to ensure privacy bags were in place at all times completed on 09.26.2019. 3.) Systemic Change Nursing staff were in-serviced by the Director of Nursing regarding dignity issues and support and care from IC perspective on 09.26.2019. The Director of Nursing or Designee will audit catheter drainage bag covers weekly for four weeks; once per month for the next two months. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the catheter drainage bag cover audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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F 550	Continued From page 3	F 550		

drainage bag in a privacy bag and the resident ' s door remained open. The urinary catheter was noted to have urine in the bag while observing from the hallway.

An observation of Resident #43 on 09/24/19 at 2:55 PM revealed the resident ' s indwelling urinary catheter drainage bag was not covered with a privacy bag while he was in bed. The urinary catheter drainage bag was visible from the door and hallway while looking into Resident #43 ' s room.

An observation of Resident #43 on 09/24/19 at 3:35 PM revealed the resident ' s indwelling urinary catheter drainage bag was not covered with a privacy bag while he was in bed. The urinary catheter drainage bag was visible from the door and hallway while looking into Resident #43 ' s room.

An interview was conducted with NA/HHC #4 on 09/24/19 at 3:35 PM. NA/HHC #4 revealed any resident with an indwelling urinary catheter should have the urinary drainage bag hanging below the bladder and it should not be on the floor. NA/HHC #4 reported when the resident was out of bed and in a wheelchair, the urinary catheter drainage bag should be placed in a privacy bag. NA/HHC #4 also added, while the resident was in bed, the urinary catheter drainage bag should be placed in a privacy bag. NA/HHC #4 reported the reason for covering the urinary catheter drainage bag was to respect the resident's dignity. NA/HHC #4 stated she overlooked the urinary catheter drainage bag not being covered while the resident was in bed and she would take care of it right away.

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F 550	Continued From page 4 An interview with the Director of Nursing (DON) on 09/26/19 at 1:25 PM revealed the privacy bag should be in place to cover a urinary catheter drainage bag whenever a resident was in bed or out of bed and in their wheelchair. The DON reported the privacy bag was used to provide dignity for the resident and she would expect the staff to cover the urinary catheter drainage bag while in bed as they were trained to do.	F 550		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640		10/18/19

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F 640	Continued From page 5 assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit an annual Minimum Data Set (MDS) assessment within 14 days of completion for 1 of 24 sampled residents (Resident #6) whose MDSs were reviewed. Findings included: Resident #6 was admitted to the facility on 11/06/15 and had diagnoses of depression, hypertension and dementia. The annual MDS dated 07/09/19 revealed under status, the word "validated." On 09/25/19 at 10:45 AM a call was placed to the state RAI (Resident Assessment Instrument)	F 640	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation.	

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F 640	Continued From page 6 Education Coordinator who confirmed that Resident #6's annual MDS dated 07/09/19 had not been transmitted. In a telephone interview on 09/26/19 at 10:45 AM MDS Nurse #1 explained that the word "validated" under status meant the assessment was a work in progress. She confirmed that the 07/09/19 annual MDS should have been completed and transmitted before the start of the survey. In an interview on 09/26/19 at 2:26 PM the Quality Compliance Administrator expressed that she expected the MDS assessments to meet the required timeframes. She indicated that she would have expected an annual MDS dated 07/09/19 to be transmitted within the 14-day window and that there needed to be more oversight with checks and balances for the transmittal of the MDSs to the state.	F 640	1.) Interventions for affected resident: 1. Resident #6□s MDS dated 07/09/2019 was signed by the assessing nurse on 10/07/19 and finalized on 10.07.2019. MDS has been transmitted to CMS. 2) Interventions for residents identified as having potential to be affected: Audit of MDS assessments was completed and all past due assessments have been completed and submitted to CMS. 3.) Systemic Change The MDS Nurses, Clinical Coordinators, CDMs, SWs were in-serviced by the Director of Nursing regarding timeliness of the MDS and the submission date of 14 days on 10.03.2019. New MDS Coordinator hired 10.09.2019 to educate and coordinate MDS assessments. The Director of Nursing or Designee will audit 14 day completion of MDS assessments weekly for four weeks; one random audit per week for 2 months. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will	

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F 640	Continued From page 7	F 640	discuss and review the results of the MDS 14 day completion audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	
F 641 SS=D	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 record review and staff interviews the facility failed to accurately code medications on two Minimum Data Sets (MDS) assessments for 1 of 24 sampled residents (Resident #62) whose MDS assessments were reviewed. Findings included: 1. Resident #62 was admitted to the facility on 12/02/17 and had diagnoses of visual hallucinations, Adult Failure to Thrive and muscle weakness. a. The annual MDS dated 07/09/19 specified Resident #62 received zero hypnotic medications during the seven day look back period. Further review of this MDS revealed this section was completed by Clinical Coordinator #4. Resident #62's Medication Administration Record (MAR) dated 07/03/19-07/09/19, which reflected the seven day look back period, revealed that Hetlioz (a hypnotic) was administered all seven days for insomnia.	F 641	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: 1. Resident #62□s MDS dated 07/09/2019 was corrected on 09/25/19 to include the administered hypnotic. Corrected MDS has been transmitted to CMS.	10/18/19

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F 641	Continued From page 8 In an interview on 09/26/19 at 11:47 AM Clinical Coordinator #4 indicated that she looked at resident's medical records to see what medications they received during the look back period. Clinical Coordinator #4 looked through the July 2019 MAR and saw the Hetlioz and asked about the medication. On being informed that the medication was classified as a hypnotic, Clinical Coordinator #4 acknowledged that she may have missed the medication but that she would check her worksheets to see. Clinical Coordinator #4 reviewed her worksheets and verified that the hypnotic had been missed and had not been recorded on the MDS. b. The significant change MDS dated 08/07/19 specified Resident #62 received an anticoagulant and a diuretic on all seven days of the seven day look back period. Further review of this MDS revealed this section was completed by Clinical Coordinator #4. Resident #62's MAR dated 08/01/19-08/07/19, which reflected the seven day look back period, revealed that zero anticoagulants and zero diuretics were administered during the look back period. In an interview on 09/26/19 at 11:47 AM Clinical Coordinator #4 indicated that she looked at resident's medical records to see what medications they received during the look back period. Clinical Coordinator #4 looked through Resident #62's August 2019 MAR and saw hydralazine. She expressed that she thought that medication was a diuretic. (The medication hydralazine is classified as a vasodilator not a diuretic). When asked about the anticoagulant she clarified that she thought aspercreme was an	F 641	2. Resident #62□s MDS dated 08/07/2019 was corrected on 09/25/2019 to include the administered anticoagulant and diuretic. Corrected MDS has been transmitted to CMS. 2) Interventions for residents identified as having potential to be affected: Audit of MDS assessments of Section M completed by CC#4 for current residents during the last quarter. 3.) Systemic Change The MDS Nurses, Clinical Coordinators, CDMs, SWs in-serviced by the Director of Nursing regarding coding accuracy of the MDS on 10.03.2019. CC #4 retrained on section M of the RAI Manual. The Director of Nursing or Designee will audit 10% of completed MDS assessments each month for the next 3 months to ensure coding of administered medications for accuracy. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the MDS medication coding audits for a minimum of three months. Suggestions and	

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F 641	Continued From page 9 anticoagulant. (The medication aspercreme is classified as a salicylate not an anticoagulant). Clinical Coordinator #4 acknowledged that she may have entered the medications incorrectly and that she would check her worksheets to see. Clinical Coordinator #4 reviewed her worksheets and verified that the anticoagulant and diuretic were data entry errors and had been recorded incorrectly on the MDS. In an interview on 09/26/19 at 2:26 PM the Quality Compliance Administrator indicated that she expected the MDS to be accurate and to reflect the medications that were given during the look back period. She stated that the MDS needed to be accurate for resident quality of care.	F 641	recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	
F 642 SS=E	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F 642		10/18/19

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F 642	Continued From page 10	F 642		

assessment; or
(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to obtain nurse signatures attesting to the accuracy and completion of assessments within time parameters documented in the Resident Assessment Instrument (RAI) for 3 of 3 sampled residents (Resident #44, #45, and #92) whose minimum data set (MDS) assessments were reviewed for compliance in section Z. Findings included:

1. a. Resident #44 was admitted to the facility on 09/20/16.

In section Z of Resident #44's quarterly minimum data set (MDS), with an assessment reference date (ARD) of 03/13/19, the licensed practical nurse (LPN) did not sign that the information in sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 05/15/19. The registered nurse (RN) did not sign that the assessment was complete until 05/16/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed

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1.) Interventions for affected resident:

Assessments for Residents #44, #45 and #92 were completed as appropriate.

2) Interventions for residents identified as having potential to be affected:

Audit of MDS assessments was completed and all past due assessments have been completed and submitted to

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F 642	Continued From page 11 that the assessments were complete, and then one of the MDS nurses transmitted the assessments. During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed. During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the ARD. During an interview with the Quality Compliance Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses. 1. b. Resident #44 was admitted to the facility on	F 642	CMS.. 3.) Systemic Change The MDS Nurses, Clinical Coordinators, CDMs, SWs were in-serviced by the Director of Nursing regarding accuracy of the MDS and the submission date of 14 days om 10.03.2019. New MDS Coordinator hired 10.09.2019 to educate and coordinate MDS assessments. The Director of Nursing or Designee will audit 14 day completion of MDS assessments weekly for four weeks; one random audit per week for 2 months. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the MDS 14 day completion audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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09/20/16.

In section Z of Resident #44's annual minimum data set (MDS), with an assessment reference date (ARD) of 06/13/19, the licensed practical nurse (LPN) did not sign that the information in sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 08/16/19. The registered nurse (RN) did not sign that the assessment was complete until 08/19/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed that the assessments were complete, and then one of the MDS nurses transmitted the assessments.

During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed.

During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse

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signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the ARD.

During an interview with the Quality Compliance Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses.

2. a. Resident #45 was admitted to the facility on 12/13/18.

In section Z of Resident #45's quarterly minimum data set (MDS), with an assessment reference date (ARD) of 03/28/19, the licensed practical nurse (LPN) did not sign that the information in sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 06/04/19. The registered nurse (RN) did not sign that the assessment was complete until 06/05/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed that the assessments were complete, and then one of the MDS nurses transmitted the assessments.

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During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed.

During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the ARD.

During an interview with the Quality Compliance Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses.

2. b. Resident #45 was admitted to the facility on 12/13/18.

In section Z of Resident #45's quarterly minimum

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data set (MDS), with an assessment reference date (ARD) of 06/15/19, the licensed practical nurse (LPN) did not sign that the information in sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 07/31/19 and 08/01/19. The registered nurse (RN) did not sign that the assessment was complete until 08/16/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed that the assessments were complete, and then one of the MDS nurses transmitted the assessments.

During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed.

During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the

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ARD.

During an interview with the Quality Compliance Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses.

3. a. Resident #92 was admitted to the facility on 10/24/16.

In section Z of Resident #92's quarterly minimum data set (MDS), with an assessment reference date (ARD) of 05/05/19, the licensed practical nurse (LPN) did not sign that the information in sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 06/18/19. The registered nurse (RN) did not sign that the assessment was complete until 06/27/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed that the assessments were complete, and then one of the MDS nurses transmitted the assessments.

During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the

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responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed.

During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the ARD.

During an interview with the Quality Compliance Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses.

3. b. Resident #92 was admitted to the facility on 10/24/16.

In section Z of Resident #92's annual minimum data set (MDS), with an assessment reference date (ARD) of 07/11/19, the licensed practical nurse (LPN) did not sign that the information in

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sections A, D, G, GG, H, I, J, L, M, N, O, P, and Q was accurate until 09/13/19. The registered nurse (RN) did not sign that the assessment was complete until 09/13/19.

During a phone interview with MDS Nurse #1 on 09/26/19 at 11:00 AM she stated clinical coordinators completed the nursing sections of the MDS assessments. She reported when all sections of the MDS assessments were completed the clinical coordinators e-mailed the MDS nurses. She commented a MDS RN signed that the assessments were complete, and then one of the MDS nurses transmitted the assessments.

During an interview with Clinical Coordinator #2 on 09/26/19 at 11:30 AM she stated it was the responsibility of clinical coordinators to make sure MDS assessments were completed within 14 days of their ARD dates. She commented this was the goal, "but we are not perfect," and sometimes the goal was missed by a little. She explained clinical coordinators e-mailed the MDS nurses when MDS assessments were completed, and the MDS nurses e-mailed back when the assessments were signed off on as completed or there were sections of the assessments which had not been completed.

During a follow-up phone interview on 09/26/19 at 2:00 PM MDS Nurse #1 stated, per guidance in the Resident Assessment Instrument (RAI), nurse signatures in section Z, attesting to the accuracy and completeness of the MDS assessments, should be dated no later than 14 days after the ARD.

During an interview with the Quality Compliance

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F 642	Continued From page 19 Administrator on 09/26/19 at 2:32 PM she stated MDS assessments should be signed off as being accurate and complete in section Z within 14 days of the ARD. She reported it was not acceptable that the nurse signatures in section Z be dated almost two months after the ARD. She commented she thought the facility's timing problem with signatures in section Z was caused by a communication problem between the clinical coordinators and the MDS nurses.	F 642		
F 686 SS=D	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, and staff and agency staff interviews the facility failed to follow physician orders to place pressure relief boots on the feet of 1 of 4 residents (Resident #212) reviewed for pressure ulcers. Findings included: Resident #212 was admitted to the facility on 09/16/19 and had diagnoses of severe protein	F 686	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal	10/18/19

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calorie malnutrition, hypertension and coronary artery disease.

The Baseline Care Plan dated 09/16/19 revealed under Cognition: a check mark next to confused. Under Skin Conditions: Other skin concerns or wounds: right heel boggy and left heel black. Under other: a check marked and handwritten note, "Bunny Boots while in bed."

The physician orders dated 09/17/19 revealed an order to elevate both lower extremities and apply boots to both feet.

There was no Minimum Data Set (MDS) information available due to Resident #212's recent admission.

In an observation on 09/22/19 at approximately 4:00 PM Resident #212 was lying on the bed. He was not wearing protective boots.

In an observation on 09/23/19 at 8:56 AM and an interview with Nurse #4 at the same time, Resident #212 was lying on the bed with the left boot in place. Nurse #4 clarified that Resident #212 was supposed to wear soft boots in bed and that although he did not like to wear the boots, he would always wear the left boot.

In an observation on 09/23/19 at 12:20 PM Resident #212 was lying on top of the covers on the bed. He was wearing non-skid socks but no boots. The boots were in the chair against the wall across from the bottom of the bed. Resident #212's heels were resting directly on the bed.

In an observation and an interview with the Agency Nursing Assistant (ANA) on 09/23/19 at

requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation.

1.) Interventions for affected resident:

For Resident #212 nursing team communicated with the physician and the order was updated to elevate heels via pressure relieving boots as tolerated due to patient non-compliance and cognitive impairment.

The pressure ulcers that resident #212 was admitted with on 09.16.2019 were completely resolved as of 10.16.2019.

2) Interventions for residents identified as having potential to be affected:

Audit to ensure pressure relieving boots are in place per physician orders completed on 10.10.2019.

3.) Systemic Change

In service for nursing staff on following physician orders and communicating any refusals or resident non-compliance of care with pressure relieving boots on 10.09.2019.

The Director of Nursing or Designee will audit all pressure relieving boots weekly

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F 686	Continued From page 21 12:24 PM, the ANA walked into Resident #212's room and placed the boots on his feet. The ANA expressed that the resident was new to her and that she had not received report from the nurse until just a minute ago and was unaware Resident #212 needed to wear the boots in bed until she had been informed by the nurse. She indicated that she could get information relating to the care of each resident from the Care Guide in the closet. The ANA stated that she had not looked at the Care Guide to see if Resident #212 had any special needs. At this point the ANA opened the closet and reviewed the Care Guide. She verified that the Care Guide did not have any information about boots written on it. She confirmed that there was a section for Skin: Floating heels (elevate heels), bunny boots (soft padded boots), prafos (specialized boots), moisture barrier, and other. No information was checked or written in this section. In an observation on 09/23/19 at 2:59 PM Nurse #4 and the Treatment Nurse entered Resident #212's room. Resident #212 was lying on top of the covers with the left boot on. There was no boot on the right foot and neither foot was elevated. Following the treatments to Resident #212's feet he refused to wear the right boot but agreed to wear the left boot. Resident #212's right foot was elevated on a rolled- up towel. The resident's heel wounds were observed and appeared to be in the same condition as they were assessed when the resident was admitted to the facility. In an interview on 09/23/19 at approximately 3:15 PM the Treatment Nurse stated that Resident #212 was supposed to wear boots while he was in bed. She indicated that the information should	F 686	for six weeks to ensure use as ordered; every other week for two months. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the pressure relieving boots as ordered audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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be on the Care Guide because if it was not then how would staff know that he was supposed to wear them.

In an interview on 09/23/19 at 4:50 PM Nurse #5 verified that she had written the Baseline Care Plan when Resident #212 was admitted. She confirmed that she should have placed the information about the boots on the Care Guide as part of the admission process. She indicated that it was important for the information to be placed on the Care Guide so staff would be aware the boots were needed because Resident #212 had pressure ulcers on the heels. Nurse #5 expressed that if Resident #212 went without boots or having his feet elevated that would not be good and could cause the pressure ulcers to worsen.

In an interview on 09/25/19 at 3:17 PM Clinical Coordinator #2 acknowledged that the facility used agency staff. She stated that all the Nursing Assistants (NAs) received report during shift change from the NA that was leaving and the nurse. She indicated that if a NA did not know something about a resident the Care Guide was in the closet or on the side of the cabinet and they could look there for the information. Clinical Coordinator #2 stated that if the information was not on the Care Guide then the NA should ask the nurse.

In an interview on 09/26/19 at 1:26 PM the Director of Nursing Services (DNS) and the Administrator of Nursing Services (ANS) acknowledged that the admission nurse (Nurse #5) should have entered the information about the boots onto Resident #212's Care Guide. They explained that anyone should be able to go

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F 686	Continued From page 23 and look at the Care Guide and get the current and correct information on how to care for the Resident. The ANS indicated that she expected the Care Guides to be completed with the correct information and for Resident #212's boots to be on as ordered so that there would be no decline in the pressure ulcers.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to follow Occupational Therapy recommendations for Carrot Hand Orthoses (a carrot shaped splinting device) to both hands in February 2019. The facility failed to follow a physician's order for an Occupational and Physical Therapy evaluation and screen for contractures in July 2019 for 1 of 2	F 688	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission	10/18/19

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	345160	A. BUILDING _____ B. WING _____	C 09/26/2019

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F 688	Continued From page 24 residents in the survey sample who had contractures-Resident #93. Findings included: Resident #93 was admitted to the facility on 01/14/09 with diagnoses that included, in part, anoxic brain damage and bilateral hand contractures. An Occupational Therapy evaluation had been completed on 02/04/19. The Clinical Impression documented interventions were warranted to address bilateral hand contractures. Carrot Hand Orthoses were recommended bilaterally to address the hand contractures and educate caregivers and nursing staff for carryover. Services were warranted to decrease a painful condition of his upper extremities and design and implement a Restorative Nursing Program (Functional Maintenance Program). An additional physician's verbal telephone order was written on 07/02/19 for Occupational Therapy and Physical Therapy to evaluate and screen Resident #93 for contractures. An observation of Resident #93 was made on 9/24/19 at 5:10 PM. Both his hands were contracted with no splints or Carrot Orthoses present. His right hand was able to be opened by staff slightly and the skin under the contracture was natural without discoloration or sores. The left hand was not able to be opened for inspection. All finger nails on both hands were clean and well groomed. No odor was present. The facility Functional Maintenance Program for February 2019 thru July 2019 documented a	F 688	of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: Resident #93 was evaluated by OT services on 09/25/2019 for management of contractures. OT is currently providing services that include carrots to manage contractures. 2) Interventions for residents identified as having potential to be affected: Audit of all residents for therapy services in the past year to ensure recommendations are in place completed on 10.09.2019. Audit of all therapy orders to ensure activation completed 10.11.2019. 3.) Systemic Change Clinical Coordinators/Therapy Director or designee will audit therapy orders through Matrix Care weekly for one month; bi-weekly for two months. Therapy Department to write all recommendations on a physician order from and submit to nursing services.	

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F 688	Continued From page 25 problem of contractures and a passive range of motion program. The goal was for Resident #93 to participate in passive range of motion as tolerated to his legs, ankles, knees, elbows and shoulders for 2 sets held for 10 seconds and to have no pain. The intervention was to provide passive range of motion as described to the resident. The Functional Maintenance Program did not include the Occupational Therapy recommendations to treat Resident #93 for bilateral hand contractures. In addition, the August and September 2019 passive range of motion flow sheets were not generated to instruct staff to deliver the restorative therapy. In an interview conducted on 09/25/19 at 11:50 AM with Occupational Therapist #1 she stated she had evaluated Resident #93 in February 2019. She stated she had not measured the degree of contracture for both his hands because the measuring tool was metal and she feared it would cause the resident increased pain. She commented she did not complete the paperwork instructing nursing staff to begin using the carrots in both the resident's hands. She felt the verbal instruction she provided to staff had been sufficient. In an interview conducted on 09/25/19 at 2:10 PM with Nurse #1 she stated she had been employed at the facility for 13 years. She commented she had been working at the facility when Resident #93 was admitted. She could not remember ever seeing a recommendation from therapy for bilateral hand carrots. In the past, she had seen the resident wearing hand rolls that were strapped on. She noted the staff had tried putting rolled wash clothes in his hands on and off for years but that he would use his teeth to pull them	F 688	Therapy Department educated on the new protocol for recommendations. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the therapy order audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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F 688	Continued From page 26	F 688		

out.

In an interview conducted on 09/25/19 at 2:55 PM with Nurse Assistant #4 she stated she had worked with Resident #93 since 2017. She remembered once they had blue sponges to put in his hands, but they had been discontinued. She commented she would put her fingers between his fingers and palms and wiggle her fingers for as long as the resident would allow to treat the contractures. She stated it was not part of a restorative therapy plan. She said Resident #93 had both his hands soaked every morning in a basin of warm water or by wrapping them in warm washcloths to treat his contractures. She was not aware the resident had a recommendation for carrots and had never seen the equipment available for use.

In an interview conducted on 09/25/19 at 3:00 PM with Nurse Assistant #7 she stated was familiar with Resident #93 and had cared for him for the last year. She did not know what a hand carrot was and had never seen one. She commented on the days she cared for the resident she put warm, soapy washcloths in his hands to clean them and prevent sores from forming.

In an interview conducted on 09/25/19 at 3:15 PM with Clinical Coordinator #1 she stated she did not know why the Functional Maintenance Program for passive range of motion for Resident #93 had been discontinued in August and September 2019. She stated she was new on the unit and was not familiar with the February 2019 recommendation for the resident to have carrots for both his hands. She was also not aware a physician's order had been written in July 2019 for therapy to evaluate and treat Resident

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F 688	Continued From page 27	F 688		

#93 for contractures.

In an interview conducted on 09/25/19 at 3:25 PM with the Household Coordinator for Timberline house she stated she was responsible for printing the flow sheets for the Functional Maintenance Program for Resident #93 in August and September 2019. She explained she was filling in for another staff member and did not realize the flow sheets were missing because she was not familiar with the flow sheets normally generated for Resident #93. She could not explain why the flow sheets for passive range of motion had been deleted from the electronic file that generated them other than there may have been an electric surge that deleted the files.

In an interview with the Director of Therapy on 09/25/19 at 4:15 PM she stated in February 2019 Occupational Therapy evaluated Resident #93 and did recommend bilateral carrots for contractures in both hands. She commented the Occupational Therapist discussed the recommendation with the Household Coordinator but failed to complete restorative therapy directive paperwork. She stated she would not have known that the carrots had not been delivered to the unit because after equipment was ordered it went directly from Central Supply to the units. Therapy did not see new equipment or deliver it to the units once it arrived at the facility. She commented there was no way to know if the resident's contractures had worsened since February because the therapist had not measured the degree of contracture when she completed the evaluation. She was surprised an order for a therapy evaluation had been ordered again in July 2019. She stated she had not seen the order prior to our conversation. She

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F 688	Continued From page 28 concluded soaking the resident's hands in warm water would not be a comparable intervention to using carrots and would not prevent further contracture decline. In an interview conducted with the Director of Nursing on 09/26/19 at 2:15 PM she stated when therapy made a treatment recommendation a handwritten document was generated by therapy describing the recommendation. The process was also to include a dialog between therapy and the nursing staff to clarify recommendations and review the proper use of any equipment recommended. Therapy was responsible for educating staff on how to use recommended equipment. She did not know why the July 2019 physician order for a therapy evaluation had not been carried out for Resident #93. She commented the normal process was for nursing to either walk to the therapy department to hand deliver orders or for nursing to place a new order in a basket for therapy to pick up. She did not know why this process had not been followed or how the order had been missed.	F 688		
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: (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.	F 732		10/18/19

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F 732	Continued From page 29 (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 observation, record review and staff interviews, the facility failed to record the correct resident census, the correct number of Registered Nurses (RN), Licensed Nurses (LVN/LPN) and Certified Nurse Aides (NAs), and the correct number of hours worked by each of those staff members categories for each shift for 5 of 5 Daily Nurse Staffing Forms reviewed. Findings included: The Daily Nurse Staffing Form dated 09/19/19 revealed the facility census was listed as 166.	F 732	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey	

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(The facility census on 09/19/19 was 98). The Daily Nurse Staffing Form contained the incorrect numbers of RNs, LVNs/LPNs and NAs, and the incorrect number of hours worked by each of those staff members categories for each shift as the numbers were based on the listed facility census of 166.

The Daily Nurse Staffing Form dated 09/20/19 revealed the facility census was listed as 166. (The facility census on 09/20/19 was 99). The Daily Nurse Staffing Form contained the incorrect numbers of RNs, LVNs/LPNs and NAs, and the incorrect number of hours worked by each of those staff members categories for each shift as the numbers were based on the listed facility census of 166.

The Daily Nurse Staffing Form dated 09/21/19 revealed the facility census was listed as 166. (The facility census on 09/21/19 was 97). The Daily Nurse Staffing Form contained the incorrect numbers of RNs, LVNs/LPNs and NAs, and the incorrect number of hours worked by each of those staff members categories for each shift as the numbers were based on the listed facility census of 166.

In an observation on 09/22/19 at 10:45 AM on entry into the facility, the Daily Nurse Staffing Form was in a plastic holder on the reception desk. The facility census was listed as 166. (The facility census on 09/22/19 was 97). The Daily Nurse Staffing Form contained the incorrect numbers of RNs, LVNs/LPNs and NAs, and the incorrect number of hours worked by each of those staff members categories for each shift as the numbers were based on the listed facility census of 166.

agency and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation.

1.) Interventions for affected resident:

No affected residents identified.

2) Interventions for residents identified as having potential to be affected:

Daily staff posting was revised on 09.27.2019 to include licensed and unlicensed staff for only certified beds verses full facility staffing for all beds as was posted and calculated correctly.

3.) Systemic Change

In-service on 10.03.2019 for staff responsible for posting daily staffing of the state□s requirement of only certified beds to be posted.

Continued daily review of daily staffing posting.

4.) Monitoring of the change to sustain system compliance ongoing:

The Quality Assurance Committee will discuss and review the results of the staff posting audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.

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F 732	Continued From page 31 The Daily Nurse Staffing Form dated 09/23/19 revealed the facility census was listed as 166. (The facility census on 09/23/19 was 97). The Daily Nurse Staffing Form contained the incorrect numbers of RNs, LVNs/LPNs and NAs, and the incorrect number of hours worked by each of those staff members categories for each shift as the numbers were based on the listed facility census of 166. In an interview on 09/26/19 at 8:48 AM Clinical Coordinator #3 stated he had filled out the Daily Nurse Staffing Form on 09/19/19, 09/20/19, and 09/23/19. He indicated he got the staffing numbers from the staff roster and got the census from the computer. He indicated that the census listed on the Daily Staffing Form and the staffing numbers were for all the beds in the facility and not just the certified beds. He clarified that he did not know that the Daily Nurse Staffing Form needed to show a separate listing for the certified beds and the licensed beds. He verified that since all the beds were listed on the Daily Nurse Staffing Form that the census, staffing numbers and the hours were all incorrect. In an interview on 09/26/19 at 1:26 PM with the Director of Nursing Services (DNS) and the Administrator of Nursing Services (ANS) they expressed that they expected the Daily Nurse Staffing Form to reflect the correct information but that they were unaware that the form was not being filled out as required.	F 732		
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	F 761		10/18/19

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F 761	Continued From page 32 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 facility failed to keep medications secured by leaving them on an over bed table in the hallway for 1 of 2 hallways (Rehabilitation halls) observed and failed to keep unattended medications stored in a resident's locked medication cabinet for 1 of 1 medication cabinets observed (room R05). Findings included: 1. During an observation on 09/22/19 at 12:36 PM an over bed table was seen in front of room R17. The door was open approximately three inches and the over bed table was not visible	F 761	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. The Health Care Center does not agree with all statements of fact or observations stated by the survey agency and reserves the right to appeal	

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F 761	Continued From page 33 from inside the room. There were two white medication bottles on the over bed table. No staff or residents were seen on the hall, but Nurse #2 opened the door and came out of room R17 within approximately 30 seconds. In an interview on 09/22/19 at 12:37 PM Nurse #2 indicated that the medications on the over bed table were Senna S 8.6-50 mg (milligrams) (a stool softener) a sealed bottle of 100 tablets and omeprazole 20 mg (a medication used to decrease the amount of stomach acid). There were seven pills left from a bottle of 14 of the omeprazole. In a follow-up interview on 09/22/19 at 2:05 PM Nurse #2 stated that the medications were for a resident who had been discharged and he had placed them on the over bed table. He verified that he was unable to see the medications from inside room R17 and indicated that he should not have left the medications unattended. He expressed that medications needed to be secured at all times so that no one could take the medications. In an interview on 09/26/19 at 1:26 PM the Director of Nursing Services (DNS) and the Administrator of Nursing Services (ANS) acknowledged that the medications had been left unattended on the over bed table. They indicated that all medications needed to be kept secured for the safety and security of everyone. 2. During an observation on 09/22/19 at 1:19 PM the medication cabinet in room R05 did not appear to be secured. Nurse #2 was able to open the medication cabinet without using any keys. The medication cabinet contained the	F 761	these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. 1.) Interventions for affected resident: No affected residents identified. 2) Interventions for residents identified as having potential to be affected: Audit of all residents□ medication cabinets to ensure functional locks on 09.23.2019. Audit of all medication rooms to ensure medications were safe on 09.23.2019. 3.) Systemic Change In-service on 09.23.2019 of Nurses and Medication Aides in reference to the safety and medication environment. Audit medication cabinets and medication rooms for safe medication storage weekly for one month; bi-weekly for one month and one random audit the next month. 4) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the medication safety audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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F 761	Continued From page 34	F 761		

following medications:

Tylenol 500 mg (pain and fever reducer) approximately 1/3 of a bottle of 100 pills
Senna S 8.6-50 mg (stool softener) approximately ½ of a bottle of 100 pills
Nystatin mouthwash (yeast infections of the mouth) approximately 265 ml (milliliters) of a 400 ml bottle
Valsartan 10 mg (lowers blood pressure) 9 pills
Prednisone 5 mg (an anti-inflammatory) 11 pills
Eliquis 5 mg (an anticoagulant) 16 pills
Protonix 40 mg (decreases stomach acid) 25 pills
Melatonin 3 mg (regulates the sleep/wake cycle) 8 pills
Flomax 0.4 mg (relaxes bladder neck and prostate muscles) 16 pills
Mirtazapine 7.5 mg (an antidepressant that is also used to stimulate appetite) 8 pills
Methotrexate 2.5 mg (used to treat rheumatoid arthritis) 12 pills

In an interview on 09/22/19 at approximately 1:20 PM Nurse #2 verified that the medication cabinet in room R05 was unsecured. He stated that the resident in the room did not administer his own medications and that the cabinet should have been locked.

In a follow-up interview on 09/22/19 at 2:05 PM Nurse #2 stated that medications should never be left unsecured and unattended. He expressed that he was not sure as to why the medication cabinet was unlocked but that medications needed to be secured so that no one could get the medications.

In an interview on 09/26/19 at 1:26 PM the DNS and ANS acknowledged that the medication

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	345160	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH CARE CENTER	1011 PORTERS NECK ROAD WILMINGTON, NC 28411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 35 cabinet had been left unsecured. They clarified that the medication cabinet had been left unsecured by a medication aide, but that Nurse #2 had been responsible for overseeing the medication aide. The DNS and ANS verified that medications should not be left unsecured for safety and security reasons and so that no one could remove the medications.	F 761		