| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345538 | A. BUILDING ______ B. WING ______ | C 12/06/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRUITTHEALTH-RALEIGH | 2420 LAKE WHEELER ROAD RALEIGH, NC 27603 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint survey was conducted 12/02/2019 through 12/06/2019. The facility was found in compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID 52CY11. | E 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>F600 D<br><br>Based on Observation, Record Review, Family Interview and Staff Interviews, the facility failed to protect a resident from neglect as evidenced by a staff member removed the call light out of reach of resident #83 for 1 of 1 Resident (Resident #83) who required extensive to total assistance with Activities of Daily Living (ADL's).<br><br>Findings Included: | F 600 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law. | 1/3/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/30/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 600 | Continued From page 1<br>Resident #83 was admitted on 03/15/2006 with a diagnosis of Traumatic Brain Injury, Seizure Disorder, Anxiety Disorder, Depression, Hyperlipidemia, Respiratory Failure, Mood Disorder due to known physiological condition, with Depressive Features.<br>The care plan dated 11/01/2019 consisted of incontinent of bowel and bladder, potential for social isolation and low activity participation related to communication deficit and limited range of motion, at risk for falls related to immobility and mechanical lift transfers, extensive to total assist with bathing, dressing, grooming, bed mobility and toileting, eating and locomotion related to right hemiplegia.<br><br>A review of the Quarterly Minimum Data Set (MDS) dated 11/01/2019 revealed impaired cognition and needed total assistance for Activities of Daily Living (ADLs) with physical assistance of one to 2 persons. Resident #83 was wheelchair bound and had limited speech deficit making his speech garbled when he spoke. The MDS also revealed Resident #83 was able to initiate the call light for assistance.<br><br>At the time of on-site survey, resident # 83 was in the hospital and was not able to be reached.<br>On 11/22/2019 on 11:49 PM per video footage provided by Resident #83's family revealed NA #2 went into Resident #83's room after Resident #83 initiated the call light because the shirt of resident #83 needed changing due to being wet. After NA#2 entered resident #83's room, NA #2 turned the call light off, and removed the call light from the resident #83's reach and exited the room. Attempts were made to contact NA#2 for interview but NA#2 did not return calls. | F 600 | Corrective Action for those residents that have been affected.<br><br>On 11/24/19 4:16 P.M. family member of resident #83 informed facility of neglect. Aide was suspended on 11/24/19 and a 24hour report was submitted to the State on 11/25/19.<br>On 11/25/19 The aide met with the Director of Health Service (DHS) admitted to removing the call bell from the residents reach intentionally at that point NA #2 was terminated.<br><br>Corrective action will be accomplished for those residents<br><br>to be affected by same deficient practice. On 12/10/2019 the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Clinical Competency Coordinator (CCC), and Clinical Supervisors On 12/10/19 an interview was conducted of all 100 alert and oriented residents to determine if they have been abused. No incident of abuse noted. On 12/11/19 A skin audit was conducted on all 40 residents that are demented or unable to answer questions regarding abuse. This was completed on 12/12/19 and did not reveal any injuries of unknown origin that would suggest abuse.<br><br>On 12/2/19 an In-service for all nurses was initiated by the DHS, ADHS, CCC, and Clinical Supervisors, and Leads. This education reviewed abuse and reporting abuse or suspicion of abuse to supervisor | |

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| F 600 | Continued From page 2<br>Video footage provided by Resident #83's family revealed NA#2 did not return to check on resident #83 from 11:49 PM - 6:00 AM as evidenced by video footage which was captured by a motion detected camera in Resident #83's room. An interview with Resident #83's family representative on 12/ 5/2019 at 12:20 PM revealed Resident #83 called his family representative approximately 6 times during the night of 11/23/2019. The family representative stated he noticed the missed calls from Resident #83 at 8:30 AM on 11/23/2019 and texted the Administrator on 11/23/2019 at 8:38 AM alerting him of the multiple missed calls and was concerned about Resident # 83.<br>Record review of the facility NA flowsheets revealed Resident #83 had no ADL care documented for shift of 11PM-7AM on 11/22/2019 into 11/23/2019.<br><br>An Interview with facility Administrator and DON on 12/04/2019 at 2:35 PM revealed the Administrator learned of the incident after receiving a text message from the resident #83's brother at 8:38 AM on 11/23/2019 alerting him of the incident. Resident #83's brother relayed to the Administrator that Resident #83's shirt was wet and needed changing when Resident #83 initiated the call light during the night. The Administrator stated he called the facility at 8:40 AM and spoke to NA #3 (staff member on-site) asking to go and check the resident #83's call light status and location of the call light in the resident #83's room. At 8:45 AM, the Administrator called the DON to inform her of the occurred incident. At 8:50 AM, NA #3 verified the call light was out of reach of resident #83 during the night. The DON stated she reviewed the staff schedule to find out which staff member was | F 600 | immediately. The facility employees 197 staff and as of 12/20/19 191 have been in-serviced. This in-service will be 100% completed by 12-24-19. Any staff member that has not completed this by that date will have it completed by their next shift or will be unable to work until this education has been completed. Abuse and reporting will be covered in the new hire orientation.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The Activity Director will discuss forms of abuse each month during the Resident Council meeting to determine if any potential residents have experienced any forms of abuse. Any forms of abuse that are discovered will be brought to the Administrators attention.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The DHS will present the findings of the Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |

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| F 600 | Continued From page 3<br>assigned to Resident #83 at the time of the incident. The DON notified NA #2 at 4:17 PM on 11/24/2019 of suspension until further notice. An interview with Nurse #1 on 12/5/2019 at 4:20 PM revealed she went into Resident #83's room on 11/23/2019 between 5:45 AM-6:30 AM and noticed the call light was on the chair in Resident #83's room. She put the call light back within reach of Resident #83 at that time. A time lapse in care to resident #83 was approximately 6 hours. The initial allegation report documented NA #2 admitted removing the call light from Resident #83 and not rounding on the resident from 11:49 PM through 6:00 AM.<br><br>The continued interview with Administrator and DON stated resident # 83's care should not have been neglected and should have been provided by facility staff. | F 600 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the | F 610 | | 1/3/20 |

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| F 610 | Continued From page 4<br>incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Observation, Record Review, Staff Interviews, and Family Interview the facility failed to provide a complete investigation of a staff member that removed a call light from a resident's reach for 1 of 1 resident that required extensive to total care per Minimum Date Set (MDS) dated 11/01/2019. (resident #83)<br><br>Findings Included:<br><br>Resident #83 was admitted on 03/15/2006 with a diagnosis of Traumatic Brain Injury, Seizure Disorder, Anxiety Disorder, Depression, Hyperlipidemia, Respiratory Failure, Mood Disorder due to known physiological condition, with Depressive Features.<br><br>The care plan dated 11/01/2019 consisted of incontinent of bowel and bladder, potential for social isolation and low activity participation related to communication deficit and limited range of motion, at risk for falls related to immobility and mechanical lift transfers, extensive to total assist with bathing, dressing, grooming, bed mobility and toileting, eating and locomotion related to right hemiplegia.<br><br>A review of the Quarterly Minimum Data Set (MDS) dated 11/01/2019 revealed impaired cognition and needed total assistance for Activities of Daily Living (ADLs) with physical assistance of one to 2 persons. Resident #83 was wheelchair bound and had limited speech deficit making his speech garbled when he spoke. The MDS also revealed Resident #83 | F 610 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br><br>On 11/24/19 4:16 P.M. family member of resident #83 informed facility of neglect. Aide was suspended on 11/24/19 and a 24hour report was submitted to the State on 11/25/19. On 11/25/19 The aide met with the Director of Health Service (DHS) admitted to removing the call bell from the residents reach intentionally at that point NA #2 was terminated.<br><br>Corrective action will be accomplished for those residents<br>to be affected by same deficient practice.<br><br>On 12/10/2019 the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Clinical Competency Coordinator (CCC), and Clinical Supervisors On 12/10/19 an | |

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F 610 Continued From page 5
was able to initiate the call light for assistance.

On 11/22/2019 on 11:49 PM per video footage NA #2 went into resident #83's room after Resident #83 initiated the call light because the shirt of resident #83 needed changing due to being wet. The NA #2 did not provide assistance in changing Resident # 83's wet shirt and upon entering the room NA#2 intentionally turned off the call light, then removed it from resident #83's bedrail, placed it out of reach of resident #83 by throwing it behind the chair in resident #83's room, and exited the room. Video footage revealed NA#2 did not return to check on resident #83 from 11:49 PM - 6:00 AM as evidenced by video footage which was captured by a camera in Resident #83's room. An interview with Resident #83's family representative on 12/ 5/2019 at 12:20 PM revealed Resident #83 called his family representative approximately 6 times during the night of 11/23/2019. The family representative stated he noticed the missed calls from Resident #83 at 8:30 AM on 11/23/2019 and texted the Administrator on 11/23/2019 at 8:38 AM alerting him of the multiple missed calls and was concerned about Resident # 83.

An Interview with facility Administrator and DON on 12/04/2019 at 2:35 PM revealed the Administrator learned of the alleged incident after receiving a text message from the resident #83's brother at 8:38 AM on 11/23/2019 alerting him of the incident. The Administrator stated he called the facility at 8:40 AM and spoke to NA #3 (staff member on-site) asking to go and check the resident #83's call light status and location of the call light in the resident #83's room. At 8:45 AM, the Administrator called the DON to inform her of the occurred incident. At 8:50 AM, NA #3 verified

F 610
interview was conducted of all 100 alert and oriented residents to determine if they have been abused. No incident of abuse noted. On 12/11/19 A skin audit was conducted on all 40 residents that are demented or unable to answer questions regarding abuse. This was completed on 12/12/19 and did not reveal any injuries of unknow origin that would suggest abuse.

On 12/2/19 an In-service for all nurses was initiated by the DHS, ADHS, CCC, and Clinical Supervisors, and Leads. This education reviewed abuse and reporting abuse or suspicion of abuse to supervisor immediately. The facility employees 197 staff and as of 12/13/10 191 have been in-serviced. This in-service will be 100% completed by 12-20-19. Any staff member that has not completed this by that date will have it completed by their next shift.
Abuse and reporting will be covered in the new hire orientation.

Measures put into place or systemic changes made to ensure that
the deficient practice will not occur.

The Activity Director will discuss forms of abuse each month during the Resident Council meeting to deterging if any potential residents have experienced any forms of abuse. Any forms of abuse that are discovered will be brought to the Administrators attention.

The facility plans to monitor its

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| F 610 | Continued From page 6<br>the call light was out of reach of resident #83 during the night. The DON stated she reviewed the staff schedule to find out which staff member was assigned to Resident #83 at the time of the incident. The DON notified NA #2 at 4:17 PM on 11/24/2019 of suspension until further notice. An interview with Nurse #1 on 12/5/2019 at 4:20 PM revealed she went into Resident #83's room on 11/23/2019 between 5:45 AM-6:30 AM and noticed the call light was on the chair in Resident #83's room. She put the call light back within reach of Resident at that time. A time lapse in care to resident #83 was approximately 6 hours. The initial allegation report documented NA #2 admitted removing the call light from Resident #83 and not rounding on the resident from 11:49 PM through 6:00 AM.<br><br>Also revealed in the above interview, the Administrator and DON stated NA #2 was terminated on 11/25/2019 as a result of her admitted actions. The Administrator and DON stated they believed the incident was isolated and stated no written statements were collected and no further in-house interviews/investigations were conducted with staff or residents. | F 610 | performance to make sure solutions are sustained.<br><br>The DHS will present the findings of the Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |
| F 640 SS=D | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§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:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments. | F 640 | | 1/3/20 |

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| F 640 | Continued From page 7<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§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.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§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. | F 640 | | |

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| F 640 | Continued From page 8<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to transmit a significant change in condition assessment in the required time for one of one resident reviewed for assessments (Resident #2).<br><br>Findings included:<br><br>A review of the medical record revealed Resident #2 was admitted on 4/30/2019 with diagnoses that included Stroke, Pneumonia, Dysphagia, oropharyngeal phase. Feeding tube.<br><br>The 60-day Minimum Data Set (MDS) dated 6/25/2019 noted Resident #2 was moderately impaired for cognition and needed extensive assistance for all Activities of Daily Living, with the help of one to two persons.<br><br>A review of records revealed a significant change assessment dated 10/24/2019 that was completed but had been rejected by the Centers for Medicare Services (CMS).<br><br>In an interview on 12/4/2019 at 10:23 AM, the MDS Nurse stated the significant change assessment was because Resident #2 had his feeding tube removed. The Nurse stated the validation report comes from corporate headquarters and was sent to her in an email. The Nurse indicated she could print it off and she went into the computer but was unable to locate the report.<br><br>On 12/6/2019 at 8:53 AM the MDS Nurse stated there had been nothing wrong with the significant change assessment, but the system asked for the | F 640 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br>On 12/4/19 during Annual Survey it was discovered that a Significant change assessment validation dated on 10/24/19 was completed but rejected by CMS. On 12/6/19 it was discovered that there was nothing wrong with the report but had asked for a date of the prior assessment done on 8/7/19. This validation was presented on 12/6/19.<br><br>Corrective action will be accomplished for those residents<br>to be affected by same deficient practice.<br><br>On 12/23/19 The MDS Nurse Manager conducted an audit of rejected assessments. On 12/23/19 there were 1 rejected assessments discovered during this audit. The MDS Nurse Manager had the items corrected and received the validation report supporting this information. | |

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| F 640 | Continued From page 9<br>date of the prior assessment, which was 8/7/2019, and when that date was entered, the significant change was rejected. The MDS Nurse noted the rejected assessment had been accepted and she had the validation that was reviewed. A review of the MDS noted the significant change MDS was accepted. | F 640 | On 12/23/19 the Transportation Lead will provide the schedule and any information on residents returning from clinical appointments. This will be reviewed by either the Director of Health Services, the Assistant Director of Health Services, or a designated Supervisor. This review will be done weekly to review the updated records for any new diagnosis that may require a Passer II referral.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The MDS Nurse Manager will review the final validation report weekly to determine if any assessments have been rejected. These assessments will then be corrected and resubmitted. This will be done weekly for three months.<br>This will be noted on the audit tool that will reference the date, the assessment, the residents, the issues causing the error, and the validation date, the MDS nurse manager initials and Administrators initials verifying review.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The MDS Manager will present the findings of the Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of | |

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F 640 Continued From page 10 F 640

compliance is obtained.

F 646 SS=D

MD/ID Significant Change Notification
CFR(s): 483.20(k)(4)

F 646 — Completion date: 1/3/20

§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to refer a resident for a Preadmission Screening and Resident Review (PASRR) Level II screening for one of one resident screened for PASRR (Resident #33).

Findings included:

A review of the medical record revealed Resident #33 was admitted 10/26/2018 with diagnoses including anxiety and depression.

A review of the Quarterly Minimum Data Set (MDS) dated 7/11/2019 revealed no diagnosis of Post-Traumatic Stress Disorder (PTSD) noted for Resident #33. The quarterly MDS dated 9/28/2019 and the Annual MDS dated 10/4/2019 had a diagnosis of PTSD for Resident #33 but no PASRR Level II screening was applied for.

On 12/4/2019 at 11:06 AM the Social Worker (SW) was interviewed, and stated Resident #33 had come in to the facility with a Level I PASRR number, so he did not need a Level II screening just because he had a new diagnosis of PTSD.

This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.

Corrective Action for those residents that have been affected.

On 12/4/19 it was observed that resident #33 had a new diagnosis of PTSD and the facility had not applied for a Passer II On 12/4/19 the Social Worker submitted a request for a PasarrII.

Corrective action will be accomplished for those residents
to be affected by same deficient practice.

On 12/9/19 the MDS Nurse Manager,

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| F 646 | Continued From page 11<br>At 11:15 AM on 12/4/2019 the MDS Nurse stated her office missed the diagnosis of PTSD for Resident #33. The MDS stated when a mental illness diagnosis is found, the SW would be notified by email or word of mouth. The MDS Nurse stated the MDS office should look at the resident diagnoses and if there was a mental illness the SW should be notified so a PASRR Level II referral could have been made. | F 646 | MDS nurses, and Social Workers initiated an audit to review any new diagnosis that would need a Passer II referral. This audit will verify any new diagnosis of mental illness that have not been captured and a Passer II submitted. Of the 147 residents, 78 have been excluded due to already having a primary diagnosis of mental illness, a Pasarr II, or a primary diagnosis of dementia. The MDS Department and Social Work Department will audit the 69 outstanding charts to determine if a diagnosis is discovered that would require a Pasarr II screen sent to Social work. This audit will be completed by 12/31/19. On 12/4/19 an Inservice was initiated by MDS Nurse Manager reviewing the process for mental diagnosis don are referring a PasarrII. On 12/24/19 all residents have been audited for the above reasons and out of the 69, 19 have been referred to Social Work for a Pasarr II screen.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>On 12/23/19 the Transportation Lead will provide the schedule and any information on residents returning from clinical appointments. This will be reviewed by either the Director of Health Services, the Assistant Director of Health Services, or a designated Supervisor. This review will be done weekly to review the updated records for any new diagnosis that may require a Passer II referral and if this is the case, they will communicate with MDS | |

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| F 646 | Continued From page 12 | F 646 | and Social Work and the referral will be submitted.<br>This audit tool will be conducted five times a week for four weeks, then three times a week for four weeks, and then once a week for four weeks. The audit tool will consist of the date of the appointment, resident name, a new diagnosis (yes or no), social work and MDS notified (yes or no), Auditor initials, Admin. initials.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The MDS Manager will present the findings of the Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the | F 690 | | 1/3/20 |

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| F 690 | Continued From page 13<br>resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to secure the urinary catheter to a leg device in 1 of 2 sampled residents (Resident #70). (Resident #70)<br><br>Findings included:<br><br>A review of the facility's indwelling urinary catheter policy on 12/4/2019 at 2:35pm noted the urinary catheter was to be properly secured and the securement device was to be assessed daily.<br><br>Resident #70 was admitted to the facility on 10/22/2019 with current diagnoses listed as benign prostate hypertrophy, uropathy, urinary tract infection in the last 30 days, non Alzheimer's dementia, Parkinson's disease and generalized | F 690 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br>On 12/4/19 it was observed that resident #70 did not have a strap for his catheter. | |

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**F 690**

Continued From page 14
muscle weakness.

The care plan for resident #70 dated 10/22/2019 for urinary tract infection and for an indwelling urinary catheter revealed an intervention to secure the catheter with a locking device to prevent tension on the urinary meatus from the catheter.

The admission Minimum Data Set (MDS) assessment dated 10/29/2019 revealed resident #70 was admitted with an indwelling catheter.

An observation on 12/3/2019 at 8:20am revealed resident #70 was resting in the bed with the urinary catheter bag on the left side of the bed. The catheter is lying across the left leg with no leg strap or locking device on the left thigh.

An observation on 12/4/2019 at 11:45am revealed the urinary catheter for resident #70 was lying on the adult brief with no leg strap or locking device to the left thigh. On 12/4/2019 at 1:34pm, a new leg strap was noted to be on the left thigh and the urinary catheter was attached.

An interview conducted on 12/4/2019 at 1:34pm with nurse assistant #4 revealed nurse #2 had applied a leg strap to resident #70 prior to perineal care on 12/4/2019 at 1:30pm. Nurse assistant #4 stated the leg straps or locking devices kept the catheter in place and prevented tension on the catheter and could be applied by nursing assistants.

An interview with nurse #2 was conducted on 12/4/2019 at 1:41pm. Nurse #2 admitted to applying the leg strap to resident #70 on 12/4/2019 at 1:30pm. Nurse #2 stated the leg

**F 690** (Plan of Correction)

On 12/4/19 resident X had the catheter strap secured to his leg.

Corrective action will be accomplished for those residents
to be affected by same deficient practice.

On 12/5/19 the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Clinical Competency Coordinator (CCC), and Clinical Supervisors, and Leads initiated an audit of all residents to determine if all residents with leg catheters had an appropriate leg strap. Of the 9 residents, with catheters, it was observed that all 9 residents had a catheter leg strap secure.

On 12/4/19 an In-service for all clinical staff was initiated by the DHS, ADHS, CCC, and Clinical Supervisors, and Leads. This education reviewed catheter leg straps for safety. Of the 57 Nurses 57 of the staff has been completed the education. The facility will have 100% completion by 12/26/19. Any staff member that has not completed this will do so prior to their next scheduled shift or they will not be able to work. This education will be part of the new hire education beginning on 12/17/19.

Measures put into place or systemic changes made to ensure that
the deficient practice will not occur.

The DHS, ADHS, CCC, and Clinical Supervisors & Leads initiated an audit tool

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| F 690 | Continued From page 15<br>strap should had been on the resident on the 12/3/2019 and earlier on 12/4/2019 and nurses checked for the presence of the leg strap or locking device every shift. Nurse #2 noted leg straps were changed as needed when soiled by the nurse or nurse assistant.<br><br>An interview with nurse #3 conducted on 12/4/2019 at 3:25pm revealed resident #70 pulled at the urinary catheter and a strap or lock device for the catheter was required to keep the catheter in place and to prevent pulling of the catheter.<br><br>An interview with the Director of Nursing on 12/6/2019 at 10:55am revealed the facility used a lock device or leg strap to secure urinary catheters, catheters were assessed every shift for the locking device, and both nurses and nurse assistants could apply the locking device. | F 690 | ensure residents with catheters have leg straps to secure. This audit tool includes the date, resident initials, date, time of audit, if it was on, actions taken, observe initials, and Admin. initials.<br>This audit tool will consist of 10 audits a week for four weeks, then 5 audits a week for four weeks, and then 2 audits a week for four weeks.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The DHS will present the findings of the Audit Tool to the<br>Quality Assurance Performance<br>Improvement Committee monthly<br>for three months or until a pattern of compliance is obtained. | |
| F 761<br>SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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. | F 761 | | 1/3/20 |

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| F 761 | Continued From page 16<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to secure medications and make them inaccessible to unauthorized staff and residents when a medication cart was left unlocked and unattended.<br><br>Findings included:<br><br>On 12/04/2019 at 05:20am the 200-hall medication cart was observed against the wall outside the nourishment station across the nurse's station unlocked with the lock pad positioned outward as Nurse #5 walked away from the medication cart and entered a locked room behind the nurse's station which made the medication cart out of Nurse #5's sight. At 5:22am, Nurse #5 exited the locked room and walked over to the medication cart. When Nurse #5 walked away from the 200-hall medication cart and entered a room half way down the hall, which made the medication cart out of Nurse #5's sight, the lock pad remained in an unlocked outward position. While Nurse #5 was in a resident's room, two staff members were observed walking by the 200-medication cart. At 5:27am, Nurse #5 exited a resident's room and walked back toward the nurse's station into the locked room behind | F 761 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br><br>On 12/4/2019 it was observed that the nurse did not lock her medication cart. The cart was locked within 10 minutes after this observation. The nurse #5 was educated after this was observed.<br><br>Corrective action will be accomplished for those residents<br>to be affected by same deficient practice.<br><br>On 12/4/2019 the Director of Health | |

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| F 761 | Continued From page 17<br>the nurse's station prior to returning to the medication cart. At 05:29am, the 200-hall medication cart lock pad was observed in an inward position, a locked position, when Nurse #5 walked away from the medication cart.<br><br>Nurse #5 was interviewed on 12/4/2019 at 5:31am and was not able to recall if the medication cart was locked or unlocked when Nurse #5 was in the resident's room. Nurse #5 stated, "it could have been unlocked" before walking away.<br><br>On 12/4/2019 at 6:00am, Nurse #6, the shift supervisor, revealed during an interview that medication carts were always to be locked when the nurse was away from the cart.<br><br>An interview with Nurse #5 on 12/4/2019 at 7:13am revealed protocol always required the medication cart to be locked when the nurse is not at the cart.<br><br>Nurse #3 stated on 12/4/2019 at 9:34am when medication carts were unattended, the medication cart was to be locked.<br><br>During an interview with the Director of Nursing (DON) on 12/5/2019 at 11:47am, the DON noted protocol required medication carts to be locked when left unattended by a nurse. | F 761 | Services (DHS), Assistant Director of Health Services (ADHS), Clinical Competency Coordinator (CCC), and Clinical Supervisors, and Leads initiated an audit of all 10 Medications carts to observe if they were locked appropriately. Of the 10 carts all unattended carts were locked.<br><br>On 12/5/19 an In-service for all nurses was initiated by the DHS, ADHS, CCC, and Clinical Supervisors, and Leads. This education reviewed the policy and importance of locking medication when nurse is not present at the cart. Of the 57 nurses 57 have been in-serviced and by 12/15/19. This in-service will be 100% completed by 12-27-19. Any nurse that has not completed by that date will have it completed by their next shift or they will be unable to work until this education is completed.<br>This will be part of the new hire orientation for nurses.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The DHS, ADHS, CCC, and Clinical Supervisors & Leads initiated an audit tool ensure medications carts are locked when the nurse is away from the cart to maintain safety. This audit tool includes the date, cart, date, time of audit, if it was locked, actions taken, observe initials, and Admin. initials.<br>This audit tool will be conducted by | |

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| F 761 | Continued From page 18 | F 761 | conducting ten observations of the medication carts weekly for four weeks, then seven observations a week for four weeks, and then three observations a week for four weeks.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The DHS will present the findings of the Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual | F 880 | | 1/3/20 |

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| F 880 | Continued From page 19<br>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and | F 880 | | |

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| (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 |
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| F 880 | Continued From page 20<br>transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record review, facility failed to disinfect the glucometer after use for checking finger stick blood glucose levels of Resident # 56 and before intending to use it for Resident # 85 for 1 of 2 residents observed during a medication pass.<br><br>Findings included:<br><br>Resident #56 was admitted to the facility on 5/18/2018. The annual minimum data set (MDS) assessment dated 5/23/2019 revealed resident #56 was severely cognitively impaired and listed a current diagnosis of diabetes mellitus.<br><br>Resident #56 was ordered finger stick blood glucose levels before meals and at bedtime with sliding scale Humalog Kwik Pen insulin.<br><br>Resident#85 was admitted to the facility on 10/31/2019. The comprehensive MDS dated 11/7/2019 revealed resident #85 was severely cognitively impaired and listed a current diagnosis of diabetes mellitus.<br><br>Resident #85 was ordered daily accuchecks every morning before breakfast.<br><br>Nurse #4, during a medication pass, was observed on 12/4/2019 at 6:08am wearing gloves and using a glucometer to perform a fingerstick | F 880 | This plan of corrections constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. This plan of corrections is prepared and submitted solely because of requirements under state and federal law.<br><br>Corrective Action for those residents that have been affected.<br><br>On 12/4/2019 it was observed that the nurse was explaining to resident # 85 of the upcoming procedure and the surveyor asked if this was a universal device. The nurse stated yes and I will sanitize and allow to dry prior to checking residents # 85s blood sugar. The nurse #4 was educated on the appropriate procedure for disinfecting the glucometer prior to use and was followed prior to checking resident #85 blood sugar level.<br><br>Corrective action will be accomplished for those residents<br>to be affected by same deficient practice. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345538 | A. BUILDING ______ B. WING ______ | C 12/06/2019 |

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| F 880 | Continued From page 21<br>blood glucose check on resident #56. Nurse #4 exited the room and placed the glucometer on the top of the medication cart before returning to resident #56 to administer sliding scale insulin for the finger stick blood glucose level of 176. Nurse #4 returned to the cart and gathered supplies for a finger stick blood glucose check for resident #85. Nurse #4 pick up the glucometer that was on the top of medication cart used on resident #56 and entered the room of resident #85. Nurse #4 knelt beside the bed informing resident #85 of the upcoming procedure when the surveyor requested to speak with Nurse #4 in the hall. When Nurse #4 was asked if the glucometer to be used was individualized to each resident or a universal device, Nurse #4 stated, "Oh, I need to sanitize the glucometer." The glucometer was cleaned with a chlorox wipe and allowed to dry prior to Nurse #4 returning to resident #85 to perform a finger stick blood glucose.<br><br>An interview with Nurse #3 on 12/5/2019 at 9:15am revealed residents in the facility do not have individualized glucometers and each medication cart had one glucometer. Nurse #3 stated the glucometer is to be disinfected between use on the residents with chlorox wipes on the cart.<br><br>When Nurse #4 was interviewed on 12/5/2019 at 9:25am, Nurse #4 noted the protocol for use of glucometers was to disinfect or sanitize the glucometer between use of the residents.<br><br>During an interview with the Director of Nursing (DON) on 12/5/2019 at 11:47am, the DON stated the glucometers were to be cleaned with a disinfectant between each resident use. | F 880 | On 12/5/19 an In-service for all nurses was initiated by the DHS, ADHS, CCC, and Clinical Supervisors, and Leads. This education reviewed the appropriate procedure for cleaning a glucometer between uses to prevent cross contamination. This includes the use of disinfectant wipe and the glucometer allowed to air dry prior to next use, per manufacturer guideline. Of the 57 clinical staff 57 have completed this education. 12/24/19. This education will be part of the new hire education beginning on 12/17/19.<br><br>Measures put into place or systemic changes made to ensure that the deficient practice will not occur.<br><br>The DHS, ADHS, CCC, and Clinical Supervisors & Leads initiated an audit tool ensure residents with blood sugar checks to ensure the infections control procedure is implemented properly. This audit tool includes the date, resident initials, date, time of audit, if it was on, actions taken, observe initials, and Admin. initials.<br>This audit tool will be conducted five times a week for four weeks, then three times a week for four weeks, and then once a week for four weeks.<br><br>The facility plans to monitor its performance to make sure solutions are sustained.<br><br>The DHS will present the findings of the Audit Tool to the<br>Quality Assurance Performance | |

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| F 880 | Continued From page 22 | F 880 | Improvement Committee monthly for three months or until a pattern of compliance is obtained. | |