STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING ______ B. WING ______	C 08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 7/27/20 through 8/4/20. Event ID # Z0ID11. Fourteen of forty one allegations were substantiated resulting in deficiencies. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) A partial extended survey was conducted.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to place a resident ' s call light (Resident #10) within reach to allow for the resident to request staff assistance for 1 of 1 resident reviewed for accommodation of needs. The findings included: Resident #10 was admitted to the facility on 5/28/20 with diagnoses that included cerebrovascular accident (CVA) with left sided hemiplegia (paralysis on one side of the body). A grievance form dated 6/2/20 for Resident #10	F 558	F 558 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Director of Nursing (DON) completed education for the nursing staff on 7/31/20, regarding positioning of call light to accommodate residents need to call for assistance. The DON validated on 7/29/20, that Resident#10□s call light was positioned	8/25/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/26/2020

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 558

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indicated a concern from the resident ' s family member related to Activities of Daily Living (ADL) care. The facility follow up of the grievance noted that the Social Worker (SW) spoke with Resident #10 and encouraged him to use his call light to request assistance.

The admission Minimum Data Set (MDS) assessment dated 6/5/20 indicated Resident #10 ' s cognition was fully intact. He had no behaviors and no rejection of care. He required the extensive assistance of 2 or more for bed mobility and supervision with set up help only for eating. He had functional limitations with range of motion on one side of his upper extremities.

Resident #10 ' s active care plan indicated he was at risk for falls related to limitations that included, in part, CVA with left sided hemiplegia. The interventions included ensuring his call light was within reach and encouraging the resident to use it for assistance as needed.

An observation and interview was conducted with Resident #10 on 7/26/20 at 12:50 PM. Resident #10 was alert and was lying on his adjustable bed in the flat position. His call light was attached by a clip to the bedsheet on the left side of his bed. Resident #10 ' s lunch tray was on the bedside table located on the right side of his bed. The resident reported that he needed staff assistance with bed mobility. He stated he was able to eat independently after set up. Resident #10 revealed he had not eaten his lunch meal as he was unable to find his call light to request assistance with adjusting his bed. He indicated he was unable to use his left hand and needed his call light to be placed on his lap or on the right side of his bed.

F 558

so he is able to utilize the use of the call light. The DON updated the resident Kardex to reflect positioning of the call light to accommodate Resident #10s need.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice

The DON and Assistant DONs completed an audit on 8/20/20, of current facility residents to identify residents needs for positioning of call light. The Kardex was updated on 8/20/20, for the residents identified to indicate call light positioning needs.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The DON and/or the ADONs completed education on 7/31/20, for the nursing staff regarding positioning of call lights to accommodate the residents need to call for assistance. Newly hired nursing staff will receive education during orientation.

The licensed nurse will assess resident upon admission, readmission, quarterly, annually and significant change to identify positioning of call light in order to accommodate the resident to call for assistance.

The MDS nurse and/or the licensed nurses will initiate or update the care plan

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An observation was conducted of Resident #10 on 7/27/20 at 12:10 PM. He was observed in bed in his room eating his lunch. His call light was clipped to the bedsheet on the left side of his bed.

An observation was conducted of Resident #10 on 7/29/20 at 8:55 AM. He was observed in bed in his room with his call light placed across his lap and clipped to the sheet.

An interview was conducted with Nursing Assistant (NA) #4 on 7/29/20 at 9:00 AM. NA #4 stated she was familiar with Resident #10 and that she was presently assigned to him. She reported that Resident #10 was unable to use his left hand. She indicated the resident utilized his call light to request assistance. NA #4 stated that Resident #10 needed to have his call light positioned across his lap as he was unable to ring the call light with his left hand. She revealed that if the call light was clipped to the left side of his bed he would not be able to reach it.

An interview was conducted with NA #5 on 7/29/20 at 10:20 AM. NA #5 stated she was familiar with Resident #10 and that she was assigned to him on 7/26/20 and 7/27/20 during the 1st shift. She indicated that Resident #10 utilized his call light to request assistance. She stated that the resident was unable to use left hand, so he preferred to have his call light placed across his lap or on his right side. The observations on 7/26/20 at 12:50 PM and 7/27/20 at 12:10 PM of Resident #10 ' s call light clipped to the bed sheet on the left side of his bed were reviewed with NA #5. She confirmed that Resident #10 would not have been able to reach his call light in that position. NA #5 stated that

F 558

to include the positioning need of the call light to accommodate the residents need. The Kardex will include the positioning of the call light.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The DON, ADON, and/or the licensed nurses will audit 10 call lights a week for 4 weeks then 20 per month for 2 months, to validate that call lights are positioned appropriately to accommodate the needs of the residents.

The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.

The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.

Indicate dates when corrective action will be complete;

8/25/20

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F 558	Continued From page 3 she had not recalled his call light being in that position on 7/26/20 or 7/27/20 but indicated that lunch time was a busy time of day and it could have been in that position without her noticing it. She explained that during lunch time she and other staff were busy passing trays, setting up residents who were able to feed themselves, and providing assistance to residents who were not able to feed themselves. She further explained that due to these factors she may not have noticed if Resident #10 ' s call light was positioned out of his reach. An interview was conducted with the Director of Nursing (DON) on 7/29/20 at 2:59 PM regarding Resident #10 ' s call light not being placed within his reach. The DON indicated her expectations were for staff to place resident call lights within the residents ' reach at all times.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		8/25/20

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F 561	Continued From page 4 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident and staff, the facility failed to put resident to bed at her preferred time (Resident #9) for 1 of 3 sampled resident's reviewed for choices. Findings included: 1. Resident #9 was admitted to the facility on 12/14/18 with multiple diagnoses including history of left wrist fracture and cardiovascular accident (CVA). The quarterly Minimum Data Set (MDS) assessment dated 7/5/20 indicated the resident's cognition was intact, and she needed extensive assistance with bed mobility and transfer. The assessment further indicated that the resident did not have any behaviors. On 7/27/20 at 12:55 PM, Resident #9 was interviewed. She stated that her main concern was the facility did not have enough staff to provide care. She stated that she previously informed staff that her preferred bed- time was between 9:00 PM to 9:30 PM. But, staff do not assist her to bed until around 11:00 PM on most nights. Resident #9 explained that when she	F 561	F 561 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Assistant Director of Nursing interviewed Resident #9 on 8/20/20, to identify her choice of bedtime. Resident #9 prefers to go to bed between 9pm-10pm. The DON revised her ADL choice care plan and kardex on 8/20/20, to include her choice of bedtime. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed education for the nursing staff on 7/30/20, regarding honoring residents choices regarding bed times and Kardex is updated with the residents bed time choice. Address how the facility will identify other	

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asked the staff to put her to bed at night, the staff would tell her that she had to wait because they didn't have enough help.

An attempt to call the Nurse Aide (NA) assigned to Resident #9 during the 3:00 PM to 11:00 PM shift was unsuccessful.

On 7/28/20 at 12:06 PM, Nurse #9, assigned on the hall Resident #9 resided, was interviewed. She stated that the hall has 40 or more residents to care for and only 1 nurse and 2 NAs assigned. The hall had a lot of residents, including Resident #9, that needed assistance with getting in and out of bed. Residents complained that they had to wait a long time to receive the care they needed. Nurse #9 verified that Resident #9 preferred to go to bed around 9:00 PM to 9:30 PM each night, but she had to wait until 11:00 PM or 11:30 PM to be put back to bed because there was not enough staff to transfer her into bed at her preferred time.

On 7/29/20 at 3:01 PM, the Director of Nursing (DON) was interviewed. She stated that she assigned staff according to the facility census. She stated that she expected the staff to provide care according to the resident's choice including being assisted to bed at their preferred bedtime.

F 561

residents having the potential to be affected by the same deficient practice;

Current facility residents have the potential to be affected by the alleged deficient practice of failure to honor residents choice for bedtime.

The DON and ADON□s completed an audit of current facility residents on 8/20/20, to identify resident choice regarding bedtimes.

The MDS nurse and/or the DON updated current facility residents care plan and Kardex on 8/20/20,to include the residents choice of bedtime.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed education for the nursing staff on 7/30/20, regarding honoring residents choices regarding bed times and Kardex is updated with the residents bed time choice.

The licensed nurse will interview the resident upon admission to identify resident choice of bedtime and will include the residents choice in the care plan and Kardex. Choices will be reviewed at least quarterly, annually and significant change.

Indicate how the facility plans to monitor

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F 561	Continued From page 6	F 561	its performance to make sure that solutions are sustained; The DON and ADONs will interview 10 residents weekly for 4 weeks then 20 residents monthly for 2 months, to validate that the resident was assisted to bed according to the residents choice of bedtime. The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 8/25/20	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and residents and record review the facility failed to provide incontinent care for 1 of 3 dependent residents (Resident #3) reviewed for activities of	F 677	F 677 Address how corrective action will be accomplished for those residents found to	8/25/20

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daily living (ADL).

The findings included:

Resident #3 was admitted to the facility on 4/26/2008 with diagnoses that included cerebral infarct (stroke), hemiplegia, and seizures.

The resident's most recent comprehensive care plan, dated 7/1/2020, addressed triggered care areas including self-care performance deficit related to left sided hemiparesis. Interventions listed on the care plan indicated the resident was total dependent for incontinent care and required extensive to total assistance by two persons.

The most recent quarterly Minimum Data Set (MDS), dated 7/3/2020, revealed Resident #3 had adequate hearing and vision and was able to make her needs known. Resident #3 was coded as being cognitively intact and without behaviors during the assessment period. The resident required physical assistance by two persons for bed mobility, transfers, activities of daily living (ADLs), toileting, and hygiene due to functional limitation of one upper and both lower extremities. Resident #3 was coded as always incontinent of bowel and bladder and required a wheelchair for locomotion.

Continuous observations of Resident #3 on 07/27/20 from 10:22 am to 10:55 am (33 minutes) revealed staff failed to provide requested incontinent care to the resident during the following observations:

Observations on 7/27/2020 at 10:22am revealed Resident #3 activated her call bell. At 10:23am the assistant activities director entered Resident

F 677

have been affected by the deficient practice;

The Director of Nursing (DON) provided education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents, which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on.

The staff will not turn off call light until care has been provided.
The DON and/or ADON has monitored call light timeliness and provision of care for Resident #3 from 8/4-8/20/20, and interviewed resident #3 on 8/20/20, to validate that staff has provided care timely according to the resident interview response.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current facility residents that are dependent upon staff for incontinence care have the potential to be affected by the deficient practice of failure to provide incontinence care timely.
The DON and the ADON’s identified current residents that require assistance with incontinence care on 7/31/20 and educated the nursing staff that those residents will need incontinence care provided at least every two hours and as needed.

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#3's room and the resident stated that she needed to be cleaned up and gotten out of the bed to her wheelchair. The assistant activities director told Resident #3 that staff would assist her when she got the stuff off of her bed. The resident had papers lying on top of her bedding. The assistant activities director turned off the residents' call bell, exited the room.

Observations on 7/27/20 at 10:25am revealed Resident #3 rang the call bell again and the assistant director of nursing (ADON) left the nurses's station and entered the resident's room within a minute. Resident # 3 informed the ADON that she had been waiting for assistance from staff since around 10:00am and stated she needed incontinence care and wanted to be dressed and placed in her wheelchair. The ADON turned off the resident's call bell and told the resident she would remind nursing assistant (NA) #2 that she needed assistance, but the NA was working with another resident at that time. The ADON was observed to exit the resident's room and returned to the nurse's station.

Observations on 7/27/20 at 10:28am revealed Resident #3 rang the call bell again. The ADON left the nurses's station and entered the resident's room a second time. The resident stated she was becoming uncomfortable and wished to be cleaned up and gotten out of bed into her wheelchair. The ADON stated the NA was still working with another resident and indicated she could not help that the NA was not free to assist the resident. The ADON turned off the resident's call bell, left the resident's room and went back to the nurses's station.

Observations on 7/27/20 at 10:29am revealed

F 677

The Director of Nursing (DON) completed education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The staff will not turn off call light until care has been provided.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Director of Nursing (DON) completed education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The staff will not turn off call light until care has been provided. Newly hired nursing staff will be educated during new hire orientation.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The DON, ADON’s and Administrator will monitor the answering of call lights 10 times a week for 4 weeks, then 20 times a week for 2 months, to validate that staff are answering call lights and providing care as needed which includes staff rounding at least every two hours and/or providing care within 30 minutes when call

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F 677	Continued From page 9 NA#1 walked past the door to Resident#3's room. The resident yelled out to her and asked her to help her. The NA entered the resident's room and explained to the resident she was on her way to assist another resident and the NA assigned to her area would be in as soon as she was available. The NA was overheard speaking kindly and professionally to the resident. The NA exited the room and answered the call bell for room 101. Observations on 07/27/20 at 10:34am revealed the resident was in bed and was overheard yelling out for NA#2. The call bell was not on at the time. Observations on 7/27/20 at 10:54 am revealed NA#2 exited another resident's room with a bag of soiled linen. She entered the dirty linens room, exited the linens room, performed hand hygiene, and immediately entered Resident #3's room to provide incontinent care. An interview was conducted with Resident #3 on 7/27/2020 at 11:34am. She reported her first request for assistance with incontinent care, during the morning of 7/27/20, was around 10:00am. She further stated she felt the facility did not staff enough NAs and this resulted in her waiting long periods of time to receive care. Resident #3 stated the longest waits for care are common on all shifts and occur daily. An interview was conducted with NA #2 on 7/27/20 at 2:00pm. She stated there are usually 3 or 4 NAs scheduled to cover the residents on the 100 and 200 halls as well as covering any residents on what is known as the T-hall. On occasions, they may have a fourth NA. She stated there were only three NAs working first	F 677	light has been turned on . The DON and Administrator will interview 5 residents weekly for 4 weeks then 10 residents monthly for 2 months, to validate that staff are answering call lights and providing necessary care within a reasonable amount of time which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The DON and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action has been completed; 8/25/20	

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shift on 7/27/2020 and it was difficult to get to all the residents in a timely manner. Sometimes they are not able to get all of the resident care completed by the end of their shift. She stated there are several residents on the 100 and 200 like Resident #3, that require two-person assistance for incontinence care and transfers. She stated the NAs have had conversations with the ADON regarding the issue of not always having enough staff to provide care to all the residents.

An interview was conducted with NA #1, at 2:50pm on 7/27/2020. She stated there are typically three or four NAs to cover the 100, 200, and T-hall residents. On first shift, 7/27/2020, there were only three NAs for first and second shift. She further stated it is difficult for three NAs to provide care to all the residents in a timely manner. She stated they do the best they can. She also indicated the NAs had brought the staffing issue to the attention of the ADON.

An interview was conducted with NA#3 on 7/29/2020 at 9:15am. She stated there are three or four NAs assigned to the 100 hall, 200 hall, and the T-hall on most days. Some days there may be only 3 on second shift with a fourth NA for a portion of second shift. She stated on 7/27/2020 there were three NAs providing care on first and second shift. She further stated they do the best they can to meet the needs of the residents but some days residents do have to wait longer than others days for care by the NAs.

An interview was conducted with the ADON on 7/27/2020 at 2:25pm. The ADON stated she considered 20 minutes to be a reasonable time for a resident to wait for incontinent care. She

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F 677	Continued From page 11 further stated the hall where Resident #3 resided was staffed with three NAs on 7/27/2020 and she felt three NAs were capable of meeting the needs of the residents in their assigned areas in a timely manner. A fourth NA was being used to provide one on one for a resident on the T hall on 7/27/2020. An interview was conducted with the Director of Nursing (DON) on 7/29/2020 2:55pm. The DON stated she expected incontinence care to be provided to residents at the time they utilize their call bell and make staff aware they are in need of incontinence care. She further stated all staff are expected to answer call bells. If the staff member is unable or not qualified to assist the resident, then the call bell should be left on and a qualified staff member should be made aware of the resident's needs. If the staff answering the call bell is qualified to assist the resident, then they should provide the requested care.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to prevent a resident who had cognitive impairment with poor decision-making skills and displayed exit seeking	F 689	Past noncompliance: no plan of correction required.	8/26/20

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behaviors from exiting the facility unsupervised for 1 of 5 sampled residents reviewed for accidents (Resident #16). Resident #16 exited the facility through a window in his room at night. Resident #16 was heard knocking on the door outside the facility which was 40 feet away from the road at 1:30 AM. Resident #16 was assessed at the facility and found to have no injuries.

Findings included:

Resident #16 was admitted to the facility on 7/16/20 with multiple diagnoses including major depressive disorder.

A wandering risk assessment was completed for Resident #16 on 7/16/20. The assessment indicated that the resident had cognitive impairment with poor decision-making skills, able to ambulate independently and had talked about the desire to go home. The assessment further indicated that wandering was a new behavior for the resident.

Resident #16 had an interim care plan dated 7/16/20. The problems were "the resident is a wanderer" and "the resident is an elopement risk". The approaches included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books and wander guard in place.

A nurse's note dated 7/16/20 at 6:13 PM, revealed Resident #16 was admitted to the facility with admitting diagnosis of acute metabolic encephalopathy. The resident was alert and oriented to self. He ambulated in room and in the hallways with no assistance. He was wandering up and down the hall looking for his wife. A

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wander guard was placed on resident due to exit seeking behavior. He was oriented to his room and his call bell but due to confusion unable to determine if he could comprehend. The resident was sitting in his room at present looking out of the window for his wife's car.

A nurse's note dated 7/17/20 at 3:30 AM, indicated that the resident was alert with confusion. He was up ambulating throughout hallway beginning of the shift.

A nurse's note dated 7/20/20 at 1:40 AM, written by Nurse #6, revealed that at approximately 1:35 AM, there was a knock at the T-hall (quarantine hall) door. Resident #16 was noted to be outside the door knocking and requesting to come back into the facility. The resident had a wander guard in place after admission, but the staff did not hear an alarm. The resident was brought back in through that door and a complete assessment was completed to check for injuries. There were no injuries noted at that time. Upon investigation of the resident's room, it was noted that the window was wide open, and the screen was detached from the window. There was an over-turned trash can and a chair beside the window. When asked, the resident stated that he stepped on the trash can and then the chair after he opened the window and climbed out. When asked how he was able to open the window he stated, "I tinkered with it until I got the screw loose". He also stated that he just wanted to walk in the garden outside, but he had to hold onto the building to keep from falling. The resident was placed in a chair at the nurse's station and a staff member sat with him through remainder of the shift. The attending physician, Director of Nursing (DON) and the family were notified of the

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incident. The maintenance director was made aware of the incident and he responded to the facility to secure the window.

The facility's investigation of the incident was reviewed. The investigation indicated that Resident #16 was noted to have exited the facility on 7/20/20 through a window in his room and was noted knocking on the T hall door. The resident has dementia and was a wander risk and was wearing a wander guard. The plan of care was to provide one on one sitter and to look for alternate placement in facility with a secured unit.

A written statement from NA #6 (assigned on the hall Resident #16 resided) dated 7/20/20 was reviewed. The written statement indicated that at 10:00 PM on 7/19/20, she tried to enter the resident's room and the resident had a chair blocking the door. She told the resident that he could not do that and moved the chair away from the door. He changed the resident and put him to bed. At around 1:35 AM, she noticed a man knocking on the T hall door, it was Resident #16. While the nurses letting the resident in, she went to the resident's room. She noticed the trash can flipped over upside down and the chair that she moved was placed under the windowsill. The window was open, and the screen was out and was placed on the ground. She helped placed the resident in a Geri chair and watched him until the maintenance came to put the window back together. She also removed the chair and put them in the hallway.

On 7/28/20 at 1:34 PM, Nurse Aide (NA) #6 was interviewed. She stated that she was assigned to Resident #16 on 7/19/20 until 11:00 PM. NA #6 reported that she last saw the resident on 7/19/20

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F 689	Continued From page 15 between 10:00 PM to 10:30 PM. The resident was very confused, and he was able to ambulate but was unsteady. The NA stated that night of 7/19/20, she found the resident in his room with the door closed and a chair was blocking behind the door. She told the resident not to close the door and to leave it open. The NA also indicated that the resident had called his wife that night to come pick him up. The NA further stated that around 1:35 AM, she heard a knock on the T hall door and Nurse #6 opened the door and noticed the resident outside. She then went to the resident's room and noticed a trash can flipped over upside down and a chair under the windowsill, and the screen was on the ground. On 8/4/20 at 3:10 PM, a follow up interview was conducted with NA #6. She indicated that she informed Nurse #6 and NA# 7 that Resident #16 had blocked his door with a chair, and she told him that he should leave the door open. She also told the nurse that she moved the chair away from the door and left the door open. NA #6 stated that when she saw the resident, he was wearing a white T shirt and an incontinent brief and was in bed. A written statement from NA #7 (assigned on the hall Resident #16 resided) dated 7/20/20 was reviewed. The statement indicated that the last time the NA saw the resident was at 1:00 AM. The resident was in his bed, looked asleep. At around 1:35 AM, there was knocking on the T hall door. She headed down the hall and noted that the nurses were letting Resident #16 in. She went to the resident's room and noted a chair by the window and the waste basket was flipped over. The window screen was out of the window and was on the ground. She then went and informed the nurses. She helped the resident	F 689		

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into a Geri chair to be watched at the nurse's station.

On 7/28/20 at 5:05 PM, NA #7 was interviewed. The NA stated that she was assigned to Resident #16 on 7/20/20 from 11:00 PM to 7:00 AM. She reported that she last saw the resident at 1:00 AM and the resident was in bed. She stated that the window was hard to open, and he must have been working on it for a while. The resident was determined to leave the building, he kept saying he wanted to go home. He was very confused and was up and down the hall throughout the night. NA #7 indicated that around 1:35 AM, there was a knock on the T hall door. Nurse #6 opened the door and the resident was outside. She then went to the resident's room and found a chair by the window and a waste basket that was flipped over. The window screen was out of window and was on the ground.

A written statement from Nurse #6 (assigned to Resident #16) dated 7/20/20 was reviewed. The Nurse stated that the last time she made rounds was after midnight medication pass. She was down the T hall at 12:30 AM. Resident #16 was lying in his bed at that time. She went back to the nurse's station and started working on her charting. She was also with another resident who needed to be monitored. She heard someone banging on the T hall door at around 1:35 AM, it was Resident #16. She brought the resident back inside, assessed him from head to toe and no injuries were noted.

On 7/28/20 at 11:51 AM, Nurse # 6 was interviewed. The nurse stated that she was assigned to Resident #16 on 7/20/20 from 7:00 PM to 7:00 AM. She stated that the last time she

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F 689	Continued From page 17 saw him was at 12:30 AM when she was passing the medications on T hall. The resident was in bed. After her medication pass, she was at the nurse's station watching another resident who was also a wanderer. She could see the hallway on the T hall but not the inside of the resident's rooms. She had 26 residents (T hall and Heritage hall) that shift with 2 nurse's aides (NAs). The NAs were doing their rounds. Resident #16 was on quarantine due to being a new admit from the hospital. He was confused and able to ambulate but was unsteady. The nurse reported that around 1:35 AM on 7/20/20, she heard a knock on the T hall door and when she opened the door, it was Resident #16. The nurse stated that it was dark outside. She assessed the resident for injury and there was none. The Nurse indicated that the resident kept saying that night "I'm going home". Nurse #6 stated that the resident had removed the screw from the window and pushed the screen out. He also placed a trash can near the window and used it to get out the building. On 8/4/20 at 2:34 PM, a follow interview was conducted with Nurse #6. She stated that Resident #16 was wearing street clothes, with pair of shoes and socks on when staff assisted him back into the facility, during the night of 7/20/20. He was carrying a plastic bag with personal clothes. He stated that he was going home. Nurse #6 also reported that she was informed by NA # 6 that the resident had his door closed and he blocked it with a chair. She was also informed by the NA that she had moved the chair away from the door and kept the door open. The Nurse indicated that she could not remember if she was informed of this before or after the incident. She stated that if she was informed before the incident, she would have done the same thing, remove the chair behind the	F 689		

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door and keep the door open.

On 7/29/20 at 8:40 AM, the Maintenance Director was interviewed. He stated that all windows had a rubber stopper that was secured into the windowsill with a screw (2 inches long) to allow the window to open 6 inches as required. He stated that the screw was hard to remove without a tool and the resident must have been messing with it for several days to be able to unscrew it. He added that the rubber stopper had been installed since the facility was built and he had changed all the rubber window stoppers to a metal stopper on 7/20/20. The Maintenance Director stated that the distance from the resident's window to the T hall door was about 40 feet.

On 7/29/20 at 8:55 AM, Resident #16 was observed lying in bed in his room. When asked about the incident where he exited the window, he replied that he did go out the window, but he could not remember the date and time. He had a sitter siting outside his door during the observation.

On 7/29/20 at 9:05 AM, the window Resident #16 exited from was observed with the Maintenance Director. It was a slide window with a metal stopper secured to the windowsill to allow the window to open for 6 inches. The distance from the window to the ground was about 3 feet high. The distance from the window to the T hall door was about 40 feet and the T hall door was about 40 feet to the road. The road was observed to have 2 lanes with a posted speed limit of 35 miles per hour.

On 7/29/20 at 3:01 PM, the Director of Nursing

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F 689	Continued From page 19 (DON) was interviewed. She stated that all facility's windows have rubber stopper secured with a screw to the windowsill. The DON reported that the resident must have been working on the screw for awhile and for some reason he was able to unscrew the stopper, opened the window and came out. She verified that the resident was a wanderer and he was wearing a wander guard. He expected the staff to monitor the resident every rounds, which was every 2 hours. On 8/4/20 at 3:34 PM, a follow up interview was conducted with the DON. She stated that she thought Resident #16 has dementia and has decreased safety awareness. The DON reported that the resident's physician had not seen him before the incident on 7/20/20 but he was notified of the incident and had seen him on 7/20/20. The DON further indicated that the care plan was reviewed and revised after the incident on 7/20/20 to include redirection, checking of windows, monitoring of behaviors that indicate a plan to exit the facility and to notify the nurse or nurse supervisor if any. The corrective action for the past non-compliance dated 7/20/20 was as follows: All items listed on this self-imposed action plan have been completed and implemented on 7/20/20 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this action plan should be considered past non-compliance as of 7/20/20. On 7/20/20, Resident #16 exited the facility unattended by opening the window in his room and using a chair to climb out of the window. He was last seen by the staff member at 1:00 AM and was noted to be sleeping. He was noted to	F 689		

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F 689	Continued From page 20 be knocking on the T-hall door at approximately 1:35 AM. Through investigation it is determined that the resident exited the facility between 1:00 AM and 1:35 AM. The DON and the Maintenance Director retraced his steps and using the fact that he is unsteady and held onto the wall it would have taken approximately 2 minutes from the time he exited the window until he reached the door he knocked on. After investigation, we were able to determine that the resident was able to move the window back and forth until he loosened the screw and was able to remove the screw and open the window completely. The resident walked around the corner of the building and knocked on the exit door for the staff to let him back into the facility. CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED: Resident #16 was assessed for injury on 7/20/20 at 1:40 AM and there was no apparent injury. The resident was placed in a wheelchair and placed at nurse ' s station for the remainder of the night so that he could be monitored. The resident was placed on one on one on 7/20/20 until such time the attending physician determines his behaviors have subsided. The resident was reassessed for elopement and care plan was updated to indicate elopement on 7/20/20. Maintenance Director responded to facility and secured the window. The Physician, DON and Administrator were made aware of situation on 7/20/20. IDENTIFICATION OF OTHER RESIDENTS: A 100% audit of all residents was conducted on 7/20/20 to ensure that all residents were present	F 689		

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F 689	Continued From page 21 in the facility. All residents were present. A 100% audit was conducted on all residents on 7/20/20 with current wander guard use and it was determined that there were 15 residents at risk for elopement. All 15 residents had a new wander risk assessment performed to determine if they had any changes since the last assessment. No other changes were noted. MEASURES FOR SYSTEMIC CHANGE: The Maintenance Director secured all windows on 7/20/20 so that they will only open to 6 inches to meet life safety guidelines while preventing resident from exiting through the windows. All staff were educated on elopement on 7/20/20 by the DON and Assistant DON and elopement will continue to be discussed during orientation for newly hired employees. HOW CORRECTIVE ACTION WILL BE MONITORED: The Maintenance Director will audit all room of residents with wander guards five times weekly for 2 weeks and then 3 times weekly for four weeks and then monthly for two months beginning 7/21/20 to ensure that the windows remain secured. These audits will be reviewed by the Administrator and or DON upon completion. DON/Assistant DON will monitor for residents that have increased exit seeking behaviors that may indicate risk for elopement through nurse ' s notes and interview daily. These audits will be completed on 5 residents at risk weekly for 4 weeks and then 10 residents monthly for 2 months. All audits will be reviewed during the monthly Quality Assurance (QA) meeting to determine continued compliance and or changes	F 689		

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F 689	Continued From page 22 needed to plan of correction (POC). This POC will continue until such times as the QA committee determines compliance has been maintained. Date of compliance: 7/21/20 On 7/29/20 as part of the validation process, the POC was reviewed and verified through review of the audit sheets, and the in-service records, observation of the windows and staff interview. Interview with the staff revealed that they had received in-service on elopement/wandering resident and a drill on missing resident on 7/20/20. A review of the audit sheets from 7/21/20 -7/27/20 of window securement by the Maintenance Director and the audit sheets of increased exit seeking behaviors by the DON/ADON and the in-service records including their sign in sheets was conducted. Observation of windows was conducted on 7/29/20. Windows were secured and could not be opened more than 6 inches. Resident #16 was observed with 1:1 Sitter on 7/29/20. The validation process verified the facility's date of compliance as 7/21/20.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		8/25/20

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	**205 RATTLESNAKE TRAIL PINEHURST, NC 28374**

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F 725 Continued From page 23

the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, observations, resident and staff interviews, the facility failed to provide sufficient nursing staff to provide incontinent care to 1 of 3 dependent residents reviewed for activities of daily living assistance (Resident #3), and put a resident in bed when requested (Resident #9) for 1 of 3 residents reviewed for choices.

The findings included:

This tag is cross referenced to:

F 725

F 725

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Cross tag F677: The Director of Nursing (DON) provided education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents, which includes staff rounding at

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F 725	Continued From page 24 F677- Based on observations and interviews with staff and residents and record review the facility failed to provide incontinent care for 1 of 3 dependent residents (Resident #3) reviewed for activities of daily living (ADL). F561- Based on record review and interviews with resident and staff, the facility failed to put resident to bed at her preferred time (Resident #9) for 1 of 3 sampled resident's reviewed for choices. On 7/27/20 at 1:10m PM an interview was conducted with Nursing Assistant (NA) #8. She stated that facility was short of staff, and frequently had anywhere from 16 to 24 residents assigned to her. Residents had complained about call lights not answered in a timely manner, showers not provided, and long waits to receive care such as assistance getting out of or being put back into bed. Nurse #8 was interviewed on 7/27/2020 at 12:05pm. She stated she worked the third shift (7:00pm- 7:00am) and the staffing at night was inadequate with 1 nurse and 2 NAs for the hall with 45-47 residents. She further stated it was impossible to provide care for that many residents. Nurse #8 stated she had discussed issue with the DON, who kept promising to improve staffing. On 7/28/2020 at 2:52 pm an interview was conducted with Nurse #9. She stated she typically worked day shift but recently was pulled to help nights shift. She stated staffing on the skilled/rehab hall at night with one nurse and over 40 residents was inadequate. Nurse #9 specified that resident medications were often	F 725	least every two hours and/or providing care within 30 minutes when call light has been turned on. The staff will not turn off call light until care has been provided. The DON and/or ADON has monitored call light timeliness and provision of care for Resident #3 from 8/4-8/20/20, and interviewed resident #3 on 8/20/20, to validate that staff has provided care timely according to the resident interview response. Cross tag 561: The Assistant Director of Nursing interviewed Resident #9 on 8/20/20, to identify her choice of bedtime. Resident #9 prefers to go to bed between 9pm-10pm. The DON revised her ADL choice care plan and kardex on 8/20/20, to include her choice of bedtime. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed education for the nursing staff on 7/31/20, regarding honoring residents choices regarding bed times and Kardex is updated with the residents bed time choice. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Cross tag 677: The DON and the ADON's identified current residents that require assistance with incontinence care on 7/31/20 and educated the nursing staff that those residents will need incontinence care provided at least every two hours and as needed.	

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F 725	Continued From page 25 administered late. On 7/29/2020 at 10:45am an interview was conducted with the Assistant Director of Nursing (ADON) who also serves as the staff development coordinator. She stated there were three NAs working the long-term care halls (100,200, T-halls) and three NAs working the skilled rehab hall. She felt three NAs could meet the needs of the residents in a timely manner. On third shift, they were allowed three nurses for a census under 90 and 4 nurses if census was over 90. The fourth nurse, a med pass nurse, could work up to six hours, but not the entire 12 hour shift. When asked if the nurses and NAs had spoken with her regarding being unable to complete their workload, she stated they had and the facility was currently trying to hire additional nurses and NAs for the facility. She also stated staffing was based on census and not acuity of care and corporate ultimately made decisions on the number of staff that could be scheduled to work.	F 725	The Director of Nursing (DON) completed education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The staff will not turn off call light until care has been provided. Cross tag 561: Current facility residents have the potential to be affected by the alleged deficient practice of failure to honor residents choice for bedtime. The DON and ADON's completed an audit of current facility residents on 8/20/20, to identify resident choice regarding bedtimes. The MDS nurse and/or the DON updated current facility residents care plan and Kardex on 8/20/20, to include the residents choice of bedtime. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Cross tag F 677: The Director of Nursing (DON) completed education on 7/31/20, for the nursing staff regarding providing timely incontinence care for dependent residents which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The staff will not turn off call light until care has been provided. Newly hired nursing staff will be educated	

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F 725	Continued From page 26	F 725	during new hire orientation.	

during new hire orientation.

Cross tag F 561: The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed education for the nursing staff on 7/31/20, regarding honoring residents choices regarding bed times and Kardex is updated with the residents bed time choice.
The licensed nurse will interview the resident upon admission to identify resident choice of bedtime and will include the resident's choice in the care plan and Kardex. Choices will be reviewed at least quarterly, annually and significant change.

The Administrator and DON will monitor staffing daily to assure that there is sufficient staff to meet the needs of the residents as evidenced by provision of incontinence care and honoring residents choices by assisting residents to bed when they choose. All nursing staff are expected to assist with answering call lights and providing care to residents. Ancillary staff, such as Social Worker, Human resource director and Activities staff are expected to answer call lights and if unable to provide care, the light should remain on and the staff member will find the appropriate staff member to provide the necessary care.

The Administrator and/or the DON completed education for the ancillary staff on 7/31/20, regarding answering of call lights and if unable to provide care, the light shall remain on and the ancillary staff member will find the appropriate staff

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F 725	Continued From page 27	F 725	member to provide the necessary care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Cross tag F 677: The DON, ADON's and Administrator will monitor the answering of call lights 10 times a week for 4 weeks, then 20 times a week for 2 months, to validate that staff are answering call lights and providing care as needed which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The DON and Administrator will interview 5 residents weekly for 4 weeks then 10 residents monthly for 2 months, to validate that staff are answering call lights and providing necessary care within a reasonable amount of time which includes staff rounding at least every two hours and/or providing care within 30 minutes when call light has been turned on . The DON and/or the Administrator will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Cross tag F 561: The DON and ADON's will interview 10 residents weekly for 4 weeks then 20 residents monthly for 2 months, to validate that the resident was	

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F 725	Continued From page 28	F 725	assisted to bed according to the resident’s choice of bedtime. The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. The Administrator and DON will review staffing ratios daily for 3 months to validate that there is sufficient staff to meet the needs of the residents as evidenced by residents receiving incontinence care timely and residents being assisted to bed per the residents choice. The Administrator and/or the DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 8/25/20	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		8/25/20

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F 761	Continued From page 29 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 observation and staff interview, the facility failed to discard expired medication and label medication with an open date for 3 of 3 medication carts observed for medication storage. (2 carts on 200 hallway and one cart on 100 hallway). Findings included: 1. On 7/27/2020 at 10:30 am an observation of medications stored in the 200 hallway medication cart was completed with Nurse #1. The following medications were observed stored in the medication cart: a Ventolin inhaler that was opened on 4/19/2020 with a discard after 30 days	F 761	F 761 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) On 7/27/20, the licensed nurse disposed of the expired, undated medications on the 200 hallway medication cart. 2) On 7/27/20, the licensed nurse disposed of the expired, undated	

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F 761

Continued From page 30

sticker that was expired, the liquid Colace (stool softener) floor stock was opened on 2/6/2020 and had a manufacturer date expired on 4/2020, a resident ' s Fluticasone nasal spray had no open date label and the manufacturer recommended to discard after open 28 days, a resident ' s Risperidone liquid (antipsychotic) was not dated when it was opened. There were 2 residents' Advair discus (inhaler) with no open date on the device.

On 7/27/2020 at 10:35 am an interview was conducted with Nurse #1 who stated that nursing was responsible to date label medication when opened and that pharmacy checked the cart for expired medication. Pharmacy was not entering the building due to COVID-19 and she did not know who was assigned to check for expired medication. Nurse #1 commented that she checked the date for medications she used.

An interview was conducted on 7/27/2020 at 1:30 pm with the Director of Nursing. She stated that medication storage check for expiration and labeling was assigned to the Unit Supervisor and nurses using the medication cart should be checking.

2. On 7/27/2020 at 12:05 pm an observation was done of medication storage in the 300 hallway) medication cart with Nurse #2. There were 2 resident Flonase nasal sprays with no open date stored in the medication cart.

On 7/27/2020 at 12:10 pm an interview was conducted with Nurse #2 who stated that pharmacy used to check the medication cart before COVID-19. Pharmacy does not enter the building during COVID-19. Cart check had not

F 761

medications on the 300 hallway medication cart.
3) on 7/27/20, the licensed nurse disposed of the expired, undated medications on the 200-213 medication cart.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current facility residents have the potential to be the alleged deficient practice of failure to date/label medications and proper storage of medications.

The Director of Nursing (DON) completed an audit of all medication carts and medication rooms on 7/30/20, to identify expired, undated/unlabeled medications and storage of medications. There were 3 inhalers, 1 insulin and 1 eye drop that were expired or not labeled when opened. These medications were disposed of on 7/30/20.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The DON and ADON completed education on 7/31/20, for licensed nurses regarding storage of medications, dating and labeling of medications and monitoring for expiration dates. Newly hired licensed nurses will be educated during new hire orientation.

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F 761	Continued From page 31	F 761		

been assigned. Nurse #2 stated that he checked the medication expiration dates of the medications he used. Nurse #2 stated the Flonase that was opened and not dated was managed by night shift.

An interview was conducted on 7/27/2020 at 1:30 pm with the Director of Nursing. She stated that medication storage check for expiration and labeling was assigned to the Unit Supervisor and nurses using the medication cart should be checking this as well.

2. On 7/27/20 at 11:15 AM, the medication cart on 200 hall (200-213 hall) was observed. There was a used bottle of Geri Lanta (liquid antacid drug) with an expiration date of 4/20, a used Symbicort (used to treat asthma and chronic obstructive pulmonary disease (COPD)) 80/4.5 inhaler that was undated, two used Incruse Ellipta inhalers (used to treat symptoms of COPD) that was undated , one used Levemir (used to treat diabetes mellitus) 100 units/milliliter (ml) vial that was undated and one used Levemir flex touch pen that was undated.

The instruction on the box of the Symbicort inhaler read "discard 3 months after removing from the foil pouch".

The instruction on the box of the Incruse Ellipta inhaler read "discard inhaler 6 weeks after opening the moisture protective foul tray or when the counter reads "0", whichever comes first". The counter read "13".

The manufacturer's specification for Levemir indicated to "dispose 42 days after opening".

On 7/27/20 at 11:20 AM, Nurse #7 was

The Licensed nurses will check medication carts and medication rooms nightly to assure medications are stored properly and dated and labeled appropriately, including monitoring medications for expiration dates.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The DON, ADON and/or the UC□s will audit medication carts and medication rooms 5 x week for 2 weeks, then weekly for 2 months to validate that medication carts and medication rooms are free of loose medications, medications are properly stored, dated and labeled, and medications are not expired.

The DON and/or the ADON will review the audits to identify patterns/trends and will adjust the plan as necessary to maintain compliance.

The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue according to the discretion of the QAPI committee.

Indicate dates when corrective action will be completed;

8/25/20

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F 761	Continued From page 32 interviewed. She looked at the bottle of Geri Lanta and verified that it was already expired and stated that she would discard the expired bottle. The Nurse also had looked at the 2 inhalers of Incruse Ellipta, the Symbicort inhaler, the Levemir vial and the Levemir pen and verified that they were not dated when opened. She indicated that these medications should have been dated when opened but they were not. The Nurse stated that the nurses were supposed to check the medication carts every shift for expired and undated medications. On 7/27/20 at 11:25 AM, the Unit Manager (UM) on 200 hall was interviewed. The UM stated that the Pharmacist was responsible for checking the medication carts for expired and undated medications, however the Pharmacist had not been coming to the facility lately, she was reviewing the resident's records remotely. On 7/29/20 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check the medication carts for expired and undated medications every shift and for the UM to check the medication carts a few times during the week. The DON also stated that she expected the manufacturer's specification for drug storage to be followed for the inhalers and insulin.	F 761		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		8/25/20

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accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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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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§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review, the facility failed to maintain complete and accurate medical records in the area of wound care for 2 (Resident #12 and Resident #11) of 2 residents reviewed for pressure ulcers. The findings included:

1. Resident #12 was admitted 6/16/20 with cumulative diagnoses of Alzheimer's Disease, contractures and pressure ulcers.

Resident #12's admission Minimum Data Set dated 6/20/20 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for one stage 2 pressure ulcer and one unstageable pressure ulcer present on admission.

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Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
The Director of Nursing (DON) completed education on 7/31/20, for the licensed nurses regarding documenting on the Treatment Administration Record (TAR) once the treatment has been completed.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current facility residents with treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING ____ B. WING ____	C 08/04/2020

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Resident #12's care plan dated 6/20/20 read he had 2 pressure ulcers present on admission with the intervention of administering his treatments as ordered.

Resident #12's June 2020 Treatment Administration Record (TAR) revealed no documented information his pressure ulcer care was provided on 6/20/20 or 6/21/20.

Resident #12's July 2020 TAR revealed no documented information his pressure ulcer care was provided on 7/2/20, 7/17/20 and 7/22/20.

A wound care observation was conducted on 7/27/20 at 11:20 AM with the Treatment Nurse. She stated Resident #12's sacral pressure ulcer was noted to have an odor soon after admission and several courses of antibiotic rounds had been completed to aide in the wound's healing. She stated the Wound Physician saw Resident #12 weekly and had been debriding both his right heel and sacral pressure ulcers. There were no observed concerns with the treatment, status of the wounds or infection control measures.
An interview was conducted on 7/29/20 at 10:15 AM with Nurse #4. He stated he worked 6/20/20 and 6/21/20 and completed Resident #12 treatments to his pressure ulcers but he forgot to document it on Resident #12's TAR.

A telephone interview was conducted on 7/29/20 at 10:30 AM with Nurse #2. He stated the Treatment Nurse was pulled to work on the medication cart on 7/17/20 and 7/22/20 and he was assigned to complete Resident #12's pressure ulcer treatments. He stated he completed the treatments but he forgot to

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orders are at risk for the alleged deficient practice of failure to maintain complete and accurate medical records related to wound care.
The Director of Nursing, Assistant Director of Nursing and Treatment Nurse completed an audit on 8/21/20, of the TAR's for current facility residents from July 1st through August 20, 2020, to validate that treatment orders were signed out by the nurse providing the treatments. There were twelve residents known to be affected by the deficient practice. Medication error reports were completed for those residents and the Medical Director was made aware. There were no orders given by the Medical Director.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Director of Nursing (DON) completed education on 7/31/20, for the licensed nurses regarding documenting on the Treatment Administration Record (TAR) once the treatment has been completed. The education will be provided for newly hired licensed nurses during new hire orientation.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The DON and/or the ADON's will audit 10 resident TARs weekly for 4 weeks then 20 monthly for 2 months, to validate that the

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document it on Resident #12's TAR.

A telephone interview was conducted on 7/29/20 at 10:35 AM with Nurse #5. She stated she recalled completing Resident #12's pressure ulcer treatments on 7/2/20 but due to multiple interruptions from families calling to inquire about their loved ones or request to do window visits, she forgot to document it on Resident #12's TAR.

An interview was conducted on 7/29/20 at 2:35 PM with the Treatment Nurse. She stated she was often pulled to work the floor passing medications. She stated when this happened, the hall nurses were responsible for completing their own treatments. The Treatment Nurse stated she knew Resident #12's pressure ulcer treatments were done because she would look at the date on the dressings to see when they were last changed.

An interview was conducted on 7/29/20 at 2:57 PM, the Director of Nursing stated it was her expectation that the nurses document on the TAR once the treatment was provided to ensure accurate and complete medical records.

2. Resident # 11 was admitted to the facility on 6/25/20 with multiple diagnoses including dementia and pressure ulcer. The admission Minimum Data Set (MDS) assessment dated 6/30/20 indicated that the resident had long and short-term memory problems and had impaired decision-making skills. The assessment further indicated that the resident had a stage IV pressure ulcer.

Resident #11 had a doctor's order dated 7/8/20 to clean the pressure ulcer with Normal Saline (NS)

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licensed nurse has signed out on the TAR upon completion of the treatment.
The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.
The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.

Indicate dates when corrective action will be completed;
8/25/20

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and to apply nickel thick layer of Santyl (debriding agent) to wound bed, pack with Calcium alginate (used to absorb heavy exudate)) and cover with absorbent dressing daily and as needed.

The July 2020 Treatment Administration Record (TAR) of Resident #11 was reviewed. The TAR did not have nurse's initial to indicate that the treatment was provided to the pressure ulcer on 7/12/20, 7/15/20, 7/18/20 and 7/23/20.

On 7/28/20 at 5:10 PM, the Treatment Nurse was interviewed. She stated that she was pulled to work on the floor on 7/12/20, 7/15/20 and 7/18/20 and the floor nurses were supposed to provide the treatment to the resident's pressure ulcer. She also stated that she had provided the treatment to the resident's pressure ulcer on 7/23/20 but she failed to put her initial on the TAR to indicate that the treatment was provided.

On 7/29/20 at 8:10 AM, Nurse #8 was interviewed. Nurse #8 was assigned to Resident #11 on 7/15/20 and 7/18/20. She stated that she had provided the treatment to the resident's pressure ulcer on 7/15/20 and 7/18/20 but did not put her initial on the TAR to indicate that the treatment was provided. She indicated that she just started working at the facility and was still learning.

On 7/29/20 at 3:05 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to put their initials on the TAR to indicate that the treatment was provided.