

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AMENDED

PRINTED: 06/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BLVD BOX 575 WEAVERVILLE, NC 28787		
(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 166 SS=E	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of the grievance log the facility failed to address grievances for 5 of 8 sampled residents reviewed for grievances. (Resident #3,#16.#17.#18, and #19).</p> <p>The findings are:</p> <p>1. Review of the grievance log dated 01/18/13 at 4:00 PM revealed Nurse Aide (NA) #5 had reported a concern regarding Resident #17. The concern form noted, Resident #17 had told NA #5 that NA #6 was rude to her and had told her that she stinks. Resident #17 said she had felt like she could do nothing right and NA #6 had put her down and made her feel bad about herself. The concern form was signed and dated as resolved on 01/18/13 by Nurse #2 and Nurse #3 but there was no documentation the grievance had been addressed.</p> <p>On 05/22/13 at 2:15 PM the Social Worker stated the grievance form was logged in the grievance book he maintained. In reviewing the concern form involving Resident #17 the Social Worker stated he did not realize the grievance had not been addressed. The Social Worker stated he would attempt to contact Nurse# 2 to ask about</p>	F 166	<p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law".</p> <p>F 166 A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behaviors of other residents.</p> <p>Resident #16 has been discharged from the facility. The Social Services Director conducted interviews with Residents #3, 17, 18 and 19 to discuss and address current concerns by completing the concern form, reporting and involving the Interdisciplinary Team to investigate the concerns and develop acceptable resolutions.</p> <p>Residents who voice concerns have the potential to be affected by the alleged deficient practice. A Risk Management Meeting including the Administrator, Director Of Nursing and Social Services Director was held on 5/28/13 to review concerns logged</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Chris MURRAY

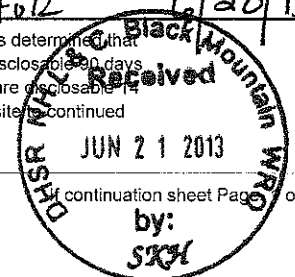
TITLE

Administrator

(X6) DATE

6/20/13

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 30 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 166	<p>Continued From page 1</p> <p>the actions taken regarding the grievance. On 5/23/13 at 10:00 AM the Social Worker stated he spoke with Nurse #2 and Nurse #2 recalled putting the concern form under the office door of the acting Director of Nursing (DON) at that time (Nurse #4). Nurse #2 stated he did not address the grievance but passed it on Nurse #4.</p> <p>On 5/23/13 at 2:45 PM the current DON stated Nurse #3 (that also signed the form) was actually the acting DON on 01/18/13 and no longer worked at the facility. The DON stated Nurse #4 also no longer worked at the facility. The DON stated she was not aware of the grievance involving Resident #17 until brought to her attention. On 5/22/13 at 3:00 PM the DON interviewed Resident #17 and reported Resident #17 did not indicate any concerns about nursing staff. The DON stated the concern should have been addressed with Resident #17 at the time the grievance was made on 01/18/13.</p> <p>2. Review of the grievance log noted a concern documented by Nurse #1 on 03/9/13 which noted the following: NA #1 and NA #2 reported to this nurse that two residents on (number of hall) hall was complaining of the rude and rough treatment they received last night on 11:00 PM-7:00 AM shift. I asked them to tell me about it. When getting the report this morning from NA #3, NA #2 stated NA#3 said, "This hall was a pain in the a-- (expletive) all night long" and walking down the hall and pointing to the residents in their rooms and said they were a pain in the a-- (expletive). Resident #3's sisters had reported earlier that they were very concerned of the treatment that Resident #3 received last night. I gave them a</p>	F 166	<p>since January 2013 and verify acceptable resolutions have been developed.</p> <p>The Administrator or designee will re-educate the Department Managers on the process for collecting concerns, investigating and developing resolution. This Education was provided by the Administrator and Director of Nursing on 6/19/2013.</p> <p>Resident concern forms will be reviewed in the Morning meetings Monday – Friday by the Administrator or designee. The resident concern forms will be reviewed to ensure investigations are complete, acceptable resolution developed and communicated with the resident and documented appropriately.</p> <p>A Risk Management Meeting will be held weekly for 12 weeks. This team will consist of the Social Worker, Unit Manager, The MDS Nurse and The Director of Nursing. The Risk Management team will review the concern log to ensure that acceptable resolution has been developed and maintained. Opportunities identified as a result of this review will be corrected weekly.</p>		

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F 166	<p>Continued From page 2</p> <p>concern form and asked them to fill it out. This nurse (Nurse #1) spoke with Resident #3 this PM and asked her to tell me what happened last night. She said the CNAs (NA #3 and NA #4) had showed no respect. She stated she had begged them to sit her up. She said they finally came out, would not speak to her. She said when she asked them what was wrong they had said nothing. She said she was afraid of them and wanted to go home. She stated they went outside of her room, laughed loudly and joked. She heard NA #3 tell NA #2 that she was a pain in the a-- (expletive). She knew NA #3 by name and described how NA #4 looked. She said she replied that she was not a pain in the a-- (expletive). Nurse #1 then spoke to Resident #16 who reported nursing assistants were rough and rude to him. He stated that they did not use gentle care with him like they used to. I assured both residents that they should not be afraid and this problem would be resolved and that I would report this to the Director of Nursing (DON).</p> <p>Attached to the above referenced concern from were other papers indicating additional grievances which included: 03/09/13-NA #7 reported Resident #18 and Resident #19 had concerns about the nursing assistants that worked the 11:00 PM-7:00 AM shift.</p> <p>Review of the medical records revealed Residents #3, #16, #18 and #19 all resided on the same hall on 03/09/13 that Nurse #1 received the complaints about 11:00 PM-7:00 AM nursing assistants. Resident #16 had discharged from the facility 05/02/13. Review of the facility assessment of his cognition on 03/24/13 noted no</p>	F 166	<p>4. Results of the data obtained during the daily and weekly audits will be analyzed for trends and reported to the Quality Assessment Performance Improvement committee monthly for a period of 3 Months or until the QAPI committee determines substantial compliance has been achieved and maintained.</p>	4/20/13	

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F 166	<p>Continued From page 3</p> <p>deficits. Resident #19 had discharged from the facility 03/29/13. Review of the facility assessment of her cognition on 02/27/13 noted no deficits.</p> <p>On 05/23/13 NA #1 stated after reporting the concern to Nurse # 1 on 03/09/13 she had not been asked any more about what was reported. NA #1 stated she recalled Resident #3 was very upset 03/09/13 because she heard NA #3 (outside her door) refer to her as a pain in the a-- (expletive). On 05/23/13 at 11:00 AM NA #2 stated after reporting the concern to Nurse # 1 on 3/9/13 she had not been asked any more questions about what was reported. NA #2 stated on the morning of 03/09/13 both she and NA #3 were walking down the hall and all the doors to resident rooms were open. NA #2 stated NA #3 was talking in a loud voice stating the residents had been a pain in the a-- (expletive) on that hall that night. NA #2 stated that NA #3 said certain residents last name and "pain in the a-- (expletive)" as the two of them walked down the hall. NA #2 stated she knows some of the residents heard what NA #3 said because Resident #3 and Resident #16 were upset all day on 03/09/13 by what they heard being said about them. On 05/22/13 at 4:55 PM NA #7 stated after reporting the concern on 03/09/13 she had not been asked any more about what was reported. NA #7 stated she recalled Resident #18 and #19 being upset about lengthy call bell response and lengthy waits for toileting assistance.</p> <p>On 05/22/13 at 4:30 PM the DON was asked about the concerns reported by Residents #3, #16, #18 and #19. The DON stated she thought she suspended NA#3 and NA #4. However,</p>	F 166			

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F 166	Continued From page 4 review of time sheets found they both worked 11:00 PM-7:00 AM on 03/08/13, were scheduled off 03/09/13 and 03/10/13 and worked 11:00 PM-7:00 AM on 03/11/13. Attached to the 03/09/13 concern form was a note from the DON to the evening supervisor dated 03/11/13 informing the evening supervisor there had been complaints from residents about resident care being rough and rude and calling residents a pain in the a-- (expletive). The memo mentioned both NA #3 and NA #4 by name and asked the supervisor to monitor their behavior and ensure that no other residents were mistreated. The note directed the evening supervisor to assign NA #3 and NA #4 to a different hall than the one they had been assigned to 03/08/13-03/09/13. The DON asked the evening supervisor to have NA #3 and NA #4 stay in the facility until she arrived so she could talk to them. A note on the 03/09/13 concern form indicated the DON met with NA #3 and NA #4 on 03/12/13 (after they worked on 03/11/13). The note indicated both NA #3 and NA #4 denied any issues during the evening shift 03/08/13-03/09/13. The note indicated both nursing assistants understood that if issues had occurred it would not be tolerated and that there should be no further concerns from residents. On 05/23/13 at 11:15 AM the DON stated she could not prove what happened with NA #3 and NA #4 the night of 03/08/13-03/09/13 because they both denied the report made by residents and NA #1 and NA #2. The DON stated she did not talk with NA #1 or NA #2 to know any further details of what they witnessed on 03/09/13. The DON stated Resident #3 denied any problems	F 166			

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F 166	Continued From page 5 with nursing staff on 03/12/13 and felt that addressed her concerns. The DON stated Resident #18 had not been interviewed about the concerns he reported to NA #7 on 03/09/13. The DON offered no explanation why Resident #18 had not been spoken to. The DON stated an incident report was done on Resident #16 because of the report received from LN #1 which noted purple bruising on both of Resident #16's lower arms. The DON wrote on this incident report that Resident #16 had many blood draws and that he took 81 milligrams of aspirin a day and felt the bruising was related to that. The incident report noted on 03/12/13 the Social Worker spoke to Resident #16 and he reported no concerns with nursing care. The DON stated she felt that interview addressed the grievance voiced by Resident #16 on 03/09/13. The DON stated she did not know Resident #16 had been upset on 03/09/13 after he overheard NA #3 refer to him as a pain in the a-- (expletive). The DON stated Nurse #5 wrote a statement on the concern form on 03/09/13 that Resident #19 "said oh, no, because if they had it would have scared me to death when asked if she felt like she had been bruised or scratched. Did not observe any bruising, scratches or abrasion." The DON stated she felt like this statement addressed the concern of Resident #19. The DON stated she was not aware of the specific concern of Resident #19. The DON stated she did not talk to NA#7 to know the specific concerns of Resident #19 (as referenced above these involved call bell response and lengthy waits for assistance with incontinence care).	F 166			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244			

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F 244	<p>Continued From page 6</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to respond to resident council grievances on call bell response time for pain medication.</p> <p>Findings included:</p> <p>An interview was conducted on 05/23/13 at 9:01 AM with the Resident Council President. (Resident #7). According to her MDS dated 04/09/13 she was assessed as cognitively intact. She stated residents had reported waiting at least a 1/2 hour or more for pain medications at least once or twice a week on all shifts. She reported it had been discussed in the March and April meetings and no follow up to the grievances occurred in the April and May meetings.</p> <p>An interview was conducted on 05/23/13 at 9:12 AM with another Resident Council participant (Resident #20). According to her MDS dated 03/08/13 she was assessed as cognitively intact. She reported residents had stated in the March and April meetings they have waited too long for pain medication. The resident reported the Activity Manager read the minutes from the month before and had not responded to the call bell response time for pain medication at the April</p>	F 244	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>Criteria I The Social Services Director conducted an interview with the Resident Council President and reviewed the Resident Council Minutes from the most recent meeting, by June 20, 2013, to verify current concerns are documented on a Concern Form, including timely call light response. Ensure the appropriate member of the Interdisciplinary Team has investigated the concerns and develop acceptable resolutions and completed the associated documentation.</p> <p>Criteria 2 All residents have the potential for being affected by this alleged deficient practice. A Risk Management meeting was held on 6/18/13 to review Resident Council concerns from January 2013 to present for appropriate and timely</p>		

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F 244	Continued From page 7 and May meetings. Review of the Resident Council minutes for March 20, 2013, April 17,2013 and May 15, 2013 revealed no documentation on follow up with grievances had been discussed. An interview was conducted on 05/22/13 at 5:30 PM with the Administrator. The administrator provided information on response to facility wide grievances. He was unable to provide information on how resident council grievances have been addressed. An interview was conducted on 05/23/13 at 8:46 AM with the Activity Manager. She reported minutes have been read at the next meeting from the meeting before. The Activity Manager stated she has written up the minutes of the meetings and had discussed with the Director of Nursing what occurred in the meetings. She revealed she had not documented follow up on grievances discussed at meetings and related she had missed the grievance on call bell response time for pain medication. An interview was conducted on 05/23/13 at 1:00 PM with the Director of Nursing. She reported her expectation for grievances expressed in resident council meetings required a documented system just for following up on resident council grievances. The Director of Nursing stated the Activity Manager had verbally discussed grievances with her addressed in resident council meetings. The Director of Nursing had not revealed she had followed up on grievances residents had expressed in the council meetings.	F 244	resolution, opportunities identified during this review will be documented as concerns and the appropriate member of the Interdisciplinary Team will investigated the concerns and develop acceptable resolutions. Those attending: Social Worker, Unit Managers, and Director of Nursing. Results were reviewed with the Administrator Criteria 3 The Department Managers were educated on the process for documenting and resolving Resident Council concerns. This education was provided by the Administrator on June 19, 2013 A Risk Management Meeting will be held weekly for a period of 3 months. This team will consist of the Social Worker, The Unit Manager, The MDS Nurse, and The Director of Nursing. The Risk Management Team will review the Resident Council minutes to ensure the concerns are listed on the Concern log and to ensure that the concerns have been resolved and follow up is complete. Opportunities		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			

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F 309 SS=D	<p>Continued From page 8 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to report to the physician an unimproved medical condition for 1 of 5 residents (Resident #5).</p> <p>Resident #5 was admitted to the facility on 12/17/09 with diagnoses including atrial fibrillation, asthma and congestive heart failure.</p> <p>Review of the Resident's medical record revealed an order dated 12/17/09 and renewed through 05/31/13 to perform head to toe skin check assessments weekly on Sundays. Another medical order dated 10/31/12 directed notification of the physician or nurse practitioner if the Resident continued to refuse medications.</p> <p>Review of the Resident's care plan dated 12/27/12 revealed her risk for pressure ulcers with a goal of having intact skin without signs of skin breakdown through the next review. An additional handwritten care plan intervention noted "observe for rash under breasts and notify MD if present."</p>	F 309	<p>identified during this meeting will be corrected by the Administrator</p> <p>Criteria 4 Results of the data obtained during the daily and weekly meetings will be analyzed for trends and reported to the Quality Assessment Performance Improvement committee monthly for a period of 3 Months or until the QAPI committee determines substantial compliance has been achieved and maintained.</p>	6/20/13	

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F 309	<p>Continued From page 9</p> <p>Review of a Change of Condition form for Resident #5 dated 01/03/13 revealed nurse documentation of red and excoriated skin under the Resident's breast and abdominal folds. The documentation further noted the condition as worse since it had started.</p> <p>Review of the Resident's medical record revealed an order dated 01/03/13 for the use of the antifungal medication nystatin powder, 100,000 units per gram (units/g) twice a day (BID) to skin folds for two weeks. Review of Resident #5's treatment administration record (TAR) for January 2013 revealed no order transcription or documentation of administration of this medication starting on 01/03/13. Another medical order dated 01/14/13 noted nystatin powder, 100,000 units/g, apply BID to skin folds for two weeks, with the word "NOW" in capital letters. This order was transcribed to the January 2013 TAR and dated 01/14/13.</p> <p>Review of the Head to Toe Skin Check form for Resident #5 for January 2013 revealed skin findings as gaudled (defined as rubbed to the point of rawness) under her breasts and/or abdominal folds on 01/20/13 and 01/27/13. Review of Resident #5's January 2013 TAR revealed nystatin powder BID administration on 01/19/13, 01/20/13, 01/26/13 and 01/27/13. All other days in the ordered two week period revealed nystatin administration once a day or no administration.</p> <p>Review of the Resident's medical record revealed no Head to Toe Skin Check Form for February 2013. Review of Resident #5's TAR for February 2013 revealed a head to toe skin check was done</p>	F 309	<p>F 309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care.</p> <p>The facility failed to report to the physician an unimproved medical condition.</p> <p>All facility residents have the potential to be effected by the alleged deficient practice and corrective action was obtained by in-services and audits as well as monitoring all change of conditions.</p> <ol style="list-style-type: none"> 1. The Nurse completed a skin assessment for resident #5 and notified the physician. The treatment order for resident #5 was clarified on 05/22/2013 and is being administered as ordered by the physician. 2. Residents with skin rashes have the potential of being affected by the alleged deficient practice. An audit of all residents with skin rashes will be completed by the DON or designee to verify accurate assessment, appropriate treatments and preventative measures 		

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F 309	<p>Continued From page 10</p> <p>on 02/10/13. Pen lines were noted around the empty initial blocks for scheduled skin checks on 02/03/13, 02/17/13 and 02/24/13. Review of the February 2013 TAR revealed an order dated 01/21/13 for nystatin powder, 100,000 units/g to skin folds BID for 14 days. Further review of Resident #5's February 2013 TAR revealed nystatin powder BID medication administration documented on 11 days and once a day administration documented on 10 days. No documented nystatin administration was noted for 2 days. Refusal of nystatin by the Resident was documented on 3 days as indicated by nurse initials surrounded by a circle.</p> <p>Review of the most recent quarterly Minimum Data Assessment dated 03/19/13 revealed the Resident had moderately impaired cognition, was usually able to understand others, had no mood traits and had rejected care during 1 to 3 days of the evaluation period. Resident #5 required limited one person assistance with personal hygiene and had moisture associated skin damage.</p> <p>Review of the Head to Toe Skin Check Form for Resident #5 for March 2013 revealed skin findings as gauded under breasts and groin on 03/03/13, 03/10/13, 03/17/13 and 03/24/13. Review of the March 2013 TAR revealed an active order for nystatin powder, 100,000 units/g, to be applied under bilateral breasts everyday and as needed until healed. Further review of Resident #5's March 2013 TAR revealed nystatin medication administration documented on 18 days and no documented nystatin administration on 12 days. Refusal of nystatin administration by the Resident was documented on 1 day as</p>	F 309	<p>are in place with notification of the physician.</p> <p>The DON or designee will audit the 24 hour reports from the past 30 days to identify current residents with skin rashes, verify accuracy of skin assessments, appropriate treatments and preventative measures are in place. This review was completed on May 18, 2013.</p> <p>3. Licensed Nurses will be re-educated by the DON or designee, regarding the Skin Management System to include accurate skin assessments, appropriate treatments, preventative measures, and physician notification. Licensed Nurses will be re-educated by the DON or designee on the identification and assessment of an acute change of condition including appropriate intervention and physician notification. This education will be completed by June 20, 2013. Any nurse not receiving education by this date will be educated prior to next scheduled shift.</p> <p>The DON or designee will review the 24 hour report 4 times per week for 12 weeks to identify residents with an acute change of condition to verify appropriate assessment, intervention, and physician notification. Opportunities identified as a result of these reviews will be corrected daily.</p>		

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F 309	<p>Continued From page 11</p> <p>indicated by nurse initials surrounded by a circle.</p> <p>Review of the Head to Toe Skin Check Form for Resident #5 for April 2013 revealed skin findings as gauded on 04/07/13, 04/21/13 and on another undated entry. Review of the April 2013 TAR revealed an active order for nystatin powder, 100,000 units/g, to be applied under bilateral breasts everyday and as needed until healed. Further review of Resident #5's April 2013 TAR revealed nystatin medication administration was not documented on any days as indicated by blank nurse initial blocks.</p> <p>Review of the Head to Toe Skin Check Form for Resident #5 for May 2013 revealed skin findings as gauded or gauded groin on 05/05/13, 05/12/13 and 05/19/12. Review of the May 2013 TAR revealed an active order for nystatin powder, 100,000 units units/g, to be applied under bilateral breasts everyday and as needed until healed. Further review of the May 2013 TAR revealed the Resident refusing nystatin powder on 05/11/13, 05/12/13, 05/18/13 and 05/19/13, as indicated by nurse initials surrounded by a circle and a capital R under these initials. No other documented nystatin medication administration was noted on the May 2013 TAR as indicated by blank nurse initial blocks.</p> <p>On 05/22/13 at 11:00 AM Nurse #6 was observed performing a skin assessment on Resident #5 while the Resident was sitting fully clothed on the toilet in her room in a confused state. After receiving permission from Resident #5, Nurse #6 exposed the skin under the Resident's left breast to reveal a white, flaky substance on the skin. Nurse #6 exposed the skin under the Resident's</p>	F 309	<p>4. The data obtained in the audits will be presented to the Quality Assessment Performance Improvement Committee for a period of 3 months or until the QAPI committee determines that substantial compliance has been achieved and maintained.</p>	6/20/13	

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F 309	<p>Continued From page 12</p> <p>right breast to reveal red, excoriated skin covered with a white flaky substance. Nurse #6 exposed the skin under the Resident's abdominal folds to reveal red, excoriated skin covered with a white flaky substance.</p> <p>On 05/22/13 at 11:15 AM, Nurse #6 was interviewed. She stated Resident #5 was known to sit for long periods of time on the toilet and place folded toilet paper under her breasts and abdominal folds. Nurse #6 stated the Resident's weekly head to toe skin checks were done on weekend shifts but she could not recall ever receiving a report about any significant skin findings. Nurse #6 stated the Resident reported in the past burning from the nystatin powder and refused it. Nurse #6 stated that based on Resident #5's skin assessment and past refusal of nystatin powder, the physician should be notified to review the assessment findings and consider new orders.</p> <p>On 05/22/13 at 11:31 AM, Nurse Aide (NA) #8 was interviewed. She stated she was aware of Resident #5's skin condition under her breasts and abdominal folds from assisting her with showers each week. NA #8 stated the Resident's skin findings had not changed from assisting her with showers over the past months and skin findings like Resident #5's should be reported to the nurse.</p> <p>On 05/22/13 at 3:17 PM Nurse #7, the wound treatment nurse, was interviewed. She stated hall nurses would tell her if they would like her to see skin conditions of concern. She stated while on the units she would ask nurses if there was anything they would want her to know regarding</p>	F 309			

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F 309	<p>Continued From page 13</p> <p>skin conditions. Nurse #7 stated Nurse #6 told her about Resident #5's skin assessment 05/22/13. Nurse #7 stated she performed a skin assessment on Resident #5 and documented her findings. Nurse #7 stated she thought Resident #5's skin under her breasts and in her abdominal folds looked like a fungal infection with red, macerated skin with bits of toilet paper. She stated she told Nurse #6 an order was required for Resident #5. Nurse #7 stated a nurse should have called the physician about Resident #5's skin condition.</p> <p>On 05/23/13 at 9:00 AM Nurse #8 was interviewed by phone. She stated she primarily worked weekend shifts and was familiar with Resident #5's skin assessments, performing her head to toe skin checks. Nurse #8 stated Resident #5's skin was frequently gaulded around her groin, under her breasts and in her abdominal folds, with the skin appearance noted as red where skin rubs against skin with heat and moisture involvement. Nurse #8 stated the Resident had an order for nystatin which would be applied to the affected areas, usually on Saturdays and again on Sundays after the Resident had a shower. Nurse #8 stated the Resident was observed to have this skin condition frequently, with it sometimes looking worse than other times but continually present. Nurse #8 stated she recalled talking to a supervisor about applying the nystatin but did not recall this issue ever being discussed with the physician. Nurse #8 stated the Resident had a history of refusing medications requiring family involvement but she was now more compliant.</p> <p>On 05/23/13 at 1:45 PM the Director of Nursing</p>	F 309			

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F 309	Continued From page 14 (DON) was interviewed. She stated her expectation was that significant assessment findings should be reported to a provider if the current treatment plan was not effective. The DON stated the physician order for nystatin written on 01/14/13 should have been transcribed to the Resident's TAR and carried out as ordered. On 05/23/13 at 3:30 PM the physician was interviewed by phone. She stated she was aware of Resident #5 getting an intermittent yeast infection under her breasts and sometimes receiving nystatin, more regularly if needed. The physician stated the Resident had past issues with refusing care. The physician stated she had not been told recently of any details regarding refusal of care. The physician stated if Resident #5's skin condition worsened or did not improve over time, she expected the nurses to notify her so she could reassess the Resident and consider a new treatment plan.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to identify and address the cause of a fall for 1 of 5 sampled residents	F 323			

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F 323	<p>Continued From page 15 reviewed for falls. (Resident #3). (Resident #3)</p> <p>The findings are:</p> <p>Resident #3 was originally admitted to the facility on 12/27/12 with diagnoses which included cerebrovascular accident (CVA) with right hemiplegia, fractured left humeral head, anxiety, peripheral vascular disease and depression.</p> <p>Review of the admission nursing assessment dated 12/27/12 noted Resident #3 required the assistance of two staff for transfers. Fall risk assessments completed 12/27/12 and 01/03/13 assessed Resident #3 with a score of 14 and greater than 10 being high risk for falls.</p> <p>The admission Minimum Data Set (MDS) dated 01/03/13 assessed Resident #3 as requiring extensive assistance of two plus staff for transfers. A note dated 01/03/13 by the MDS coordinator noted, "Resident states that she requires two persons to assist her with transfers from the wheelchair to bed." The initial care plan dated 01/03/13 included the following problem areas: Requires staff assistance and intervention for completion of ADL (activity of daily living) needs. Requires extensive assistance utilizing two staff members with approaches to this problem area including refer to therapy services as indicated and individual/caregiver education as needed. At risk for falls related to new admission, recent fall, history of previous falls, ambulatory/incontinence, balance problems/standing, balance problems/walking, utilizes assistive device, decreased muscle coordination, CVA, osteoporosis and</p>	F 323	<p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law".</p> <p>F 323 The Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Resident # 3 was assessed for injuries at the time of fall on 01/21/2013 and none were found. Resident has no other falls. Resident # 3 is now listed as a 2 person total assist for transfers.</p> <p>Residents who have had a fall in the facility have a potential of being affected by this alleged deficient practice. The DON or designee will complete an audit of residents who have fallen in the facility during the last 30 days to verify complete investigation and implementation of appropriate interventions</p>		

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F 323	<p>Continued From page 16</p> <p>psychotropics. Approaches to this problem area included resident requires two person assist/transfer at all times.</p> <p>Resident #3 was treated by a physical therapist from 12/28/12-03/21/13. On 05/22/13 at 3:00 PM a physical therapy assistant familiar with Resident #3 stated Resident #3 had always required assistance of two nurse aides with transfers.</p> <p>Review of nurses notes in the medical record of Resident #3 revealed an entry dated 01/18/13 which noted: Delayed entry for January 14th, 2013. Nurse Aide reported she was going to start getting residents ready for bed. Nurse at nurses station charting. Approximately one hour later the Nurse Aide reported that Resident #3 was sitting on the floor and that she needed help getting her up and onto the bed. Asked Nurse Aide if resident had fallen. The Nurse Aide assured the Nurse that she had not fallen and that she tried to transfer resident from the wheelchair to bed independently and resident pivoted without difficulty then began to teeter to the right and stated I can't do this and sat down. Resident sat down on the Nurse Aide and the Nurse Aide lowered her slowly to the floor. No injury reported. The resident did not hit the floor. The resident sat totally on the Nurse Aide and the Nurse Aide had to wiggle out from under the resident. The Nurse checked the resident's range of motion approximately five minutes later. Able to move all extremities as moved previous. Resident did not complain of pain or discomfort. Two Nurse Aides assisted resident to standing position. Resident pivoted to the left and sat on the bed and the two Nurse Aides assisted resident into a supine position.</p>	F 323	<p>The DON or designee will re-educate all Nursing Staff on following care planned interventions to prevent further incidents and accidents. When a fall occurs, the Interdisciplinary Team will verify an accurate investigation has occurred and appropriate interventions have been implemented based on the results of the investigation. Education will be completed by June 20, 2013. Any nurse not receiving education by this date will be educated prior to next scheduled shift.</p> <p>The DON or designee will review resident incidents and accidents 4 times per week for 12 weeks to verify accurate investigations and appropriate interventions have been implemented.</p> <p>Results of the data obtained during these reviews will be analyzed for trends and reported to the Quality Assessment Performance Improvement committee</p>		

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F 323	Continued From page 17 An interdisciplinary post fall report dated 01/21/13 was signed as completed by the Director of Nursing (DON). The summary of the interdisciplinary team indicated, "Resident to be a two person assist due to weakness. Care plan updated by MDS nurse." On 05/22/13 at 1:15 PM the DON and MDS coordinator reviewed the 01/18/13 nursing note in the medical record of Resident #3 along with the interdisciplinary post fall report. The MDS coordinator verified that, prior to the fall on 01/14/13, Resident #3 required two staff for transfers. The MDS coordinator and DON could not explain why this was not identified during their assessment of the fall or why the same intervention (two plus assist) was put into place to prevent further falls of Resident #3.	F 323	monthly for a period of 3 Months or until the QAPI committee determines substantial compliance has been achieved and maintained.	6/20/13	