STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to keep the urinary catheter bag covered for 3 (Residents #198, #212 & #208) of 3 sampled residents with an indwelling urinary catheter and failed to assist a resident to dress in her own clothes appropriate to the time of day for 1 (Resident # 198) of 1 sampled resident observed wearing a hospital gown. Findings included: 1 a. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and needed extensive assistance with dressing. The care plan dated 8/5/14 indicated that the resident was dependent with activities of daily living (ADLs) and the staff was to provide all ADLs for the resident. On 9/23/14 at 11:45 AM and 4:30 PM and 9/24/14 at 10:55 AM and 3:30 PM, Resident #198 was observed in bed wearing a hospital gown. On 9/24/14 at 3:30 PM, NA # 1 was interviewed. She stated that Resident #198 was dressed in a hospital gown everyday because she had only 2-3 outfits available. She added when Resident #198 was up in wheelchair, she had to wear her own clothes but that was very rare. Most of the time	F 241	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. F241 F241 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Residents #198, #212 and #208 have catheter bags covered. Resident #198 was provided personal clothing by facility laundry on September 24, 2014. Corrective action will be accomplished for those residents having potential to be	10/20/14

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

Electronically Signed | 10/29/2014

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F 241	Continued From page 1 her outfits were in the laundry for washing and she didn't have anything to wear but hospital gown. NA #1 indicated that she didn't know if the social worker was aware that Resident #198 needed more clothing but she had not informed her about it. On 9/24/14 at 3:35 PM, the closet of Resident #198 was observed. In the closet, one T-shirt, one blouse, one pair of pants and a house coat were observed. On 9/24/14 at 3:36 PM, the administrative staff #3 was interviewed. She stated that she was not aware that Resident #198 needed more clothes. She indicated that she had checked the closet and acknowledged that the resident needed more clothing. She indicated that she will call the family to bring in more clothes for her. 1 b. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment, had an indwelling urinary catheter and a stage IV pressure ulcer. On 9/23/14 at 11:45 AM and 4:30 PM and 9/24/14 at 10:55 AM and 3:30 PM, Resident #198 was observed with an indwelling catheter attached to a urinary bag. The urinary bag was observed with amber colored urine and was not covered. The catheter bag was in view of the room mate. On 9/24/14 at 10:55 AM, the room mate of Resident #198 was observed to have a family member visiting and the urinary bag was not covered. On 9/24/14 at 11:05 AM, Nurse #3 was interviewed. She stated that urinary catheter bag should be covered at all times but didn't know why Resident #198's bag was not covered.	F 241	affected by the same deficient practice: On September 24, 2014 an audit was conducted for all residents with indwelling catheters to ensure that all residents with indwelling catheters have their catheter bags covered. Residents noted without indwelling catheter bags covered were provided with privacy bags and indwelling catheter bags were covered. On September 24, 2014 an audit was conducted by nursing staff for 100% of all residents to ensure that personal clothing was available. Residents noted without personal clothing were provided personal clothing by responsible party and/or facility per laundry. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Beginning September 26, 2014 education began by the Staff Development Coordinator and/or Director of Nursing for all staff on dignity as it relates to covering of indwelling catheter bags. Staff will be required to receive in-service training prior to returning to work. Beginning September 26, 2014 education began by Staff Development Coordinator and/or Director of Nursing for all staff on dignity as it relates to personal clothing and ensuring that residents are properly dressed in own clothes appropriate to the time of day per resident request. Staff will be required to receive in-service training prior to returning to work.	

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F 241	Continued From page 2 On 9/24/14 at 4:25 PM, Nurse #2 was interviewed. She stated that she was not aware that Resident #198's catheter bag had no privacy cover on it. She added that she was just informed that the privacy bag for Resident #198 was left in the wheelchair and therefore she did not have one in the bed. 2. Resident # 208 was admitted 9/9/14 with cumulative diagnoses that included end stage renal disease, urinary retention, and hypothyroidism. Review of the care plan dated 9/9/14 revealed Resident # 208 had a plan of care for her indwelling urinary catheter that included putting a privacy cover over the catheter bag. Review of the Admission Minimum Data Set (MDS) dated 9/16/14 revealed Resident # 208 was cognitively intact and had an indwelling urinary catheter. On 9/23/14 at 8:46 AM Resident # 208 was observed in bed. The indwelling urinary catheter bag did not have a privacy cover on it. Resident # 208 was interviewed at this time and stated that she would prefer it if the urinary catheter bag had a privacy cover on it. On 9/25/14 at 10:10 AM Nursing Assistant # 2 (NA # 2) was observed giving morning care to Resident # 208. There was a privacy cover on Resident # 208's indwelling urinary catheter bag. NA # 2 was interviewed at this time and stated that she did not know why the privacy cover had not previously been on the urinary catheter bag but that she thought it was added the previous evening.	F 241	The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and/or Director of Nursing make rounds daily to ensure that resident dignity is maintained. Monitoring during rounds will include covering of indwelling catheter bags and residents properly dressed in own clothes appropriate to the time of day per resident request. Rounds will completed daily x 1 month, weekly x 2 months and monthly x 4 months. Social Worker will meet with all new admissions within 72 hours to ensure personal clothing available. All new admission charts will be reviewed by Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and/or Director of Nursing for personal clothing inventory list within 24 hours. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will review results of daily rounds conducted by Unit Manager / Unit Coordinator, Nursing Supervisor , Staff Development Coordinator and/or Director of Nursing to identify any issues related to covering of indwelling catheter bags and residents dressed in own clothing appropriate to the time of day per resident request.	

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F 241	Continued From page 3 3. Resident # 212 was admitted 9/12/14 with cumulative diagnoses that included coronary artery disease, hypertension and urinary retention. The interim care plan for Resident #212 dated 9/12/14 was reviewed and revealed that Resident # 212 was to receive indwelling urinary catheter care. Review of the Admission Minimum Data Set (MDS) dated 9/19/14 revealed Resident # 212 was cognitively impaired and had an indwelling urinary catheter. On 9/24/14 at 8:52 AM Resident #212 was observed in bed. She had an indwelling urinary catheter that did not have a privacy cover on it. The catheter bag was attached to her bed in view of her room mate. On 9/24/14 at 11:05 AM, Nurse #3 was interviewed. She stated that urinary catheter bags should be covered at all times. On 9/25/14 at 7:30 AM resident #208 was observed up in her wheelchair. The catheter bag had a privacy cover on it.	F 241	The Director of Nursing will report the findings of the daily rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. The Administrator will review results of 72 hour meeting conducted by Social Worker to identify any issues related to personal clothing. The Administrator will present the findings of the 72 hour meeting review to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion October 20, 2014.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		10/20/14

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F 279	Continued From page 4 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to develop a care plan to address the use of the indwelling urinary catheter and for the care of the left hand contracture for 1 of 4 sampled residents with indwelling catheters and with contractures (Resident #198). Findings included: 1 a. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and had an indwelling urinary catheter. The care area assessments (CAAs) for urinary incontinence and indwelling urinary catheter indicated to proceed to care plan. The comprehensive care plan was reviewed. There was no care plan to address the use of the indwelling catheter.	F 279	F279 F279 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #198 has care plans in place for use of an indwelling catheter and management of left hand contracture. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 24, 2014 an audit was conducted by the MDS coordinator for all residents with indwelling catheters and contractures. Residents without	

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F 279	Continued From page 5 The physician's orders were reviewed. The attending physician had ordered to insert an indwelling catheter to Resident #198 on 7/24/14 to promote healing of the stage IV sacral pressure ulcer. On 9/23/14 at 11:45 AM and 4:30 PM and 9/24/14 at 10:55 AM and 3:30 PM, Resident #198 was observed with an indwelling catheter attached to a urinary bag. On 9/24/14 at 12:40 PM, MDS Nurse #2 was interviewed. She acknowledged that the care plan for the use of the indwelling catheter was missed. She added that she will check the care plans of all residents with an indwelling catheter to make sure that they had care plans in place. 1 b. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia and joint contracture. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and had limitation in range of motion on one side. The occupational therapy (OT) notes dated 7/23/14 indicated that Resident #198 had " pain in left upper extremity from previous cerebrovascular accident (CVA) which limits passive range of motion to left upper extremity. Left hand contracted at wrist and proximal interphalangeal/distal interphalangeal joints with poor hygiene noted. Therapist performed hand hygiene to prevent skin breakdown to left hand. Will assess need for left hand splint. " On 8/25/14, OT services were discontinued as Resident #198 had reached her maximum potential. The comprehensive care plan dated 8/5/14 was reviewed. There was no care plan to address the	F 279	appropriate care plans in place for the use of an indwelling catheter and/or management of a contracture had care plans put into place. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 24, 2014 education was done for MDS department by the Director of Nursing on expectation of care plan completion as it relates to indwelling urinary catheters and management of contracture. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator, MDS coordinator and / or Director of Nursing will review all admission charts within 24 hours for physicians orders for the use of indwelling urinary catheters and/or contractures to ensure that appropriate care plan is in place. The MDS Coordinator will review all physician telephone orders during daily clinical meeting for physician orders for indwelling urinary catheters and/or management of a contracture. Upon receipt of telephone order care plan will be updated by the MDS Coordinator at that time. The MDS Coordinator will review all resident care plans at least quarterly to ensure that appropriate care plans are in place to address the use of indwelling	

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F 279	Continued From page 6 left hand contracture. On 9/23/14 at 10:50 AM and 9/24/14 at 3:18 PM, Resident #198 was observed in bed with her left hand contracted. On 9/25/14 at 2:25 PM, MDS Nurse #1 was interviewed. She acknowledged that the care plan for the left hand contracture for Resident #198 was missed and it was an oversight on their part.	F 279	urinary catheters and/or management of contractures. The Director of Nursing will review MDS care plan review for accuracy weekly x six months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will report the results of 24 hour admission chart audit and quarterly care plan reviews to the Quality Assurance and Performance Improvement Committee for monthly for six months or until a pattern of compliance is obtained. Date of completion: October 20, 2014	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations, the facility failed to follow the care plan for the application of a splint for one of four sampled residents (Resident #37) reviewed for	F 282	F 282 Corrective action will be accomplished for the resident found to have been affected	10/20/14

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F 282	Continued From page 7 range of motion. The findings included: Resident #37 was admitted to the facility on 8/30/04 and readmitted on 2/15/11 with multiple diagnoses including multiple sclerosis, contracture of the hand, abnormal posture and dysphagia. A review of the Minimum Data Set (MDS) dated 9/3/14 was conducted. Resident #37 was assessed as having severe cognitive impairment. The MDS indicated the resident was assessed as having functional limitation in range of motion of the upper extremities on both sides of her body. A review of the Restorative Nursing Program Care Plan for Resident #37 was conducted. The plan of care dated August, 2014 and September, 2014 indicated the resident was to have a splint applied to her left hand and to wear the splint for six hours a day. A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day. " A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/18/14, 8/19/14, 8/23/14, 8/24/14, 8/25/14, 8/26/14, 8/28/14, 8/29/14, and 8/31/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014.	F 282	by the deficient practice: Resident #37 has splint applied per physician orders. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 26, 2014 residents with physician orders for splinting were reviewed. Orders for splinting were placed on the resident Medication Administration Record requiring the licensed nurse to ensure splint in place and/or place the splint per physician□s orders. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education began by the Staff Development Coordinator and / or Director of Nursing for nursing staff in reference to expectation for splint application and documentation of splint application. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will review Medication Administration Records in coordination with rounds to ensure that splinting is completed and documented per physician orders daily x 2 weeks, weekly x 4 weeks then monthly x 4 months.	

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F 282	Continued From page 8 A review of the Restorative Roster for the month of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3/14, 9/4/14, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014. On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand. On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left hand. On 9/24/14 at 5:30 PM the resident was observed sitting in her wheelchair in the dayroom without a splint device on her left hand. An interview was conducted with Administrative Staff #2 on 9/25/14 at 9:24 AM. She stated one restorative aide was expected to work six days per week, not including Sunday. She stated, at times, the restorative aide had been removed from her duties in restorative nursing and instructed to work as a nurse aide (NA) on a resident hall. She stated she was unaware of how often the restorative aide was instructed to work as a NA because she did not report back to her when it occurred. Administrative Staff #2 stated the nurses on the resident halls were expected to place the left hand splint on Resident #37 when the restorative aide was removed from her duties in restorative nursing. She stated the nursing staff was not notified when the restorative aide was removed from her duties in restorative nursing. She also stated the restorative aide was expected	F 282	The Director of Nursing will review Medication Administration Record Audits daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the Medication Administration Record audits as it relates to splinting to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 20, 2014.	

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F 282	Continued From page 9 to document splint placement on the Restorative Nursing Program Flow Record. The restorative aide was expected to document if the resident refused to have a splint placed on the Restorative Nursing Program Flow Record. Administrative Staff #2 was unable to explain why the left hand splint was not placed on Resident #37 daily as indicated on the care plan for the months of August 2014 and September 2014. An interview was conducted with Restorative Aide #1 on 9/25/14 at 10:25 AM. Restorative Aide #1 stated she had been pulled from her restorative nursing duties and instructed to work as a NA on a resident hall approximately two times a month. She stated she did not notify Administrative Staff #2 when she was removed from her duties in restorative nursing. She stated Resident #37 has never refused to allow placement of her left hand splint. She stated if a resident refused to allow splint placement, the restorative aide was expected to document the refusal on the flow record and to notify the hall nurse. She stated the restorative aides work Monday through Saturday. Restorative Aide #1 was unable to explain why the left hand splint was not placed on Resident #37 daily as indicated on the care plan for the months of August 2014 and September 2014.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.	F 309		10/20/14

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE RALEIGH, NC 27616**

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, the facility failed to use leg rests on the wheelchair for one of one resident reviewed for positioning which resulted in resident's feet dangling (Resident #123) and failed to assess and monitor the dialysis access site/shunt daily each shift according to the facility policy for one of one resident reviewed for dialysis (Resident #105). The findings included: 1. Resident #123 was admitted to the facility 12/23/11. Cumulative diagnoses included: CVA (cerebrovascular accident) with hemiplegia on the non-dominant side and dementia. An annual Minimum Data Set (MDS) dated 8/25/14 indicated Resident #123 had short term and long term memory impairment and was moderately impaired in decision-making. She required extensive assistance with transfers, and extensive assistance with locomotion on and off the unit. Ambulation did not occur during the assessment period. Her balance was impaired for moving on and off the toilet and surface to surface transfers (only able to stabilize with staff assistance). Limitation in range of motion was indicated on one side for the upper extremities and no limitation in range of motion for the lower extremities. Mobility device checked was noted as wheelchair. On 9/23/14 at 10:00 AM, Resident #123 was observed sitting in her wheelchair in her room. There were no leg rests on the wheelchair at the time of the observation. Both feet were noted not	F 309	F 309 F 309 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #123 has leg rests to wheelchair in place. Resident #105 has her dialysis access site / shunt check daily each shift according to facility policy. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 26, 2014 an audit was completed for all residents to ensure that leg rests were in place to wheelchairs as indicated. Leg rests were provided to residents as indicated. On September 26, 2014 an audit was completed for all residents requiring dialysis to ensure that dialysis access site / shunt check daily each shift according to facility policy. The assessment of access site / shunt check daily each shift was added to Medication Administration Records for licensed nurse to document assessment.	

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	345529	A. BUILDING _____ B. WING _____	C 09/25/2014

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F 309	Continued From page 11 touching the floor and there was no support provided for her feet. On 9/23/14 at 11:30 AM, Resident #123 was observed sitting in her wheelchair. No leg rests were on the wheelchair. There was no support provided for her feet and both feet were not touching the floor. On 9/24/14 at 9:39 AM, Resident #123 was observed sitting in her wheelchair in her room. Both feet were hanging down and not touching the floor. No leg rests were noted on the wheelchair and there was no support provided for her feet. On 9/24/14 at 3:51 PM, Resident #123 was observed in the dining room. There were no leg rests attached to the wheelchair and both feet were dangling with no support provided for her feet. On 9/24/14 at 3:51 PM, the nurse manager #1 stated they did not use leg rests for Resident #123 because she had a restless right leg and moved around in her wheelchair by pulling on the side rails in the hallway using her right arm and did not use her feet to manipulate the wheelchair. Nurse manager #1 asked Resident #123 to move her feet. Resident #123 moved her right leg but was unable to touch the floor. On 9/25/14 at 7:28 AM, NA #3 stated the leg rests were part of the wheelchair and should be put on whenever Resident #123 was in her wheelchair because they aided with proper positioning. On 9/25/14 at 8:22 AM, Administrative staff #1 stated she expected staff to put the leg rests on	F 309	Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education began by the Staff Development Coordinator and / or Director of Nursing for nursing staff on expectation of placement of leg rests to wheelchairs as indicated. On September 26, 2014 education began by the Staff Development Coordinator and/ or Director of Nursing for licensed nurses on expectation of assessment and documentation of assessment of dialysis access site / shunt check daily each shift. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will complete rounds daily on all residents to ensure that leg rests are in place to resident wheelchairs as indicated. Rounds will be done daily x one month, weekly x 2 months then monthly x 4 months. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will audit Medication Administration Records to ensure documentation of assessment of dialysis site / shunt daily each shift. Audits will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review results	

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F 309	Continued From page 12 the wheelchair for Resident #123 for foot support and to avoid foot drop (difficulty lifting the front part of your foot with inability to maintain your foot in the proper position). On 9/25/14 at 10:07 AM, the occupational therapist stated when Resident #123 was up in the wheelchair, the leg rests should be in place for proper support of her legs/ feet. 2. Resident # 105 was admitted to the facility to the facility 4/10/13 with last readmission dated 9/28/13. Cumulative diagnoses included: end stage renal disease and dialysis. A facility policy titled "Hemodialysis" , undated, stated, in part, "assessment of dialysis resident: 1. Assess each shift the feel for the thrill or use the stethoscope to listen for bruit." A care plan dated 6/16/14 and last reviewed and updated 9/11/14 indicated Resident #105 required hemodialysis for ESRD (end stage renal disease). Approaches included: hemodialysis three times a week. Assess shunt to arm for thrill/ bruit to ensure patency. Notify physician promptly if any changes were noted. A Quarterly Minimum Data Set (MDS) dated 9/16/14 indicated Resident #105 was cognitively intact. The assessment indicated she had received dialysis during the assessment period. Nursing notes from June 1, 2014 through September 24, 2014 were reviewed and revealed the following nursing documentation regarding the thrill and bruit of the left arm shunt: 6/1/14,	F 309	of rounds completed in reference to application of leg rests daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review Medication Administration Record audits daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the rounds completion review as it relates to the application of leg rests to resident wheelchairs and the Medication Administration Record audit as it relates to assessment and documentation of assessment of dialysis site / shunt to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 20, 2014.	

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F 309	Continued From page 13 6/2/14, 9/10/14, 9/11/14, 9/16/14, 9/17/14, 9/19/14 and 9/24/14. No documentation was noted regarding assessment of the shunt for thrill and bruit from 6/2/14 through 9/9/14. Dialysis resident communication sheets (completed by the facility and sent with Resident #105 to dialysis and returned by dialysis to the facility) from June 1, 2014 through September 24, 2014 were reviewed and revealed, on the following dates, the assessment of the shunt for thrill and bruit were not noted on return from dialysis: 6/2/14, 6/4/14, 6/18/14, 7/4/14, 7/7/14, 7/14/14, 7/16/14, 7/21/14, 7/28/14, 7/30/14, 8/13/14, 8/22/14 and 8/27/14. On 9/23/14 at 10:00 AM, Resident #105 stated she went to dialysis around 6:00 AM on Monday, Wednesday and Friday. She said the dialysis staff would put a bandage on her shunt site which was located on her left lower arm when dialysis was completed. Resident #105 said she removed the bandage the next day. She stated no one at the facility checked her arm, touched the shunt site or listened to the shunt site to make sure it was functioning properly. Resident #105 stated everything was done at dialysis On 9/24/14 at 5:30 PM, Nurse #1 stated she checked Resident #105's shunt for thrill and bruit every day but did not necessarily document the results every day. She stated, if she documented the results, it would be in her nursing notes. On 9/25/14 at 11:28 AM, Nurse #2 stated she checked Resident #105's shunt site for thrill and bruit only on dialysis days. On 9/25/14 at 1:29 PM, Administrative staff #1	F 309		

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F 309	Continued From page 14 stated she expected the nursing staff to follow the facility policy and check the shunt site for thrill and bruit every shift. She stated she expected that information to be documented either in the nursing notes on non-dialysis days or on the dialysis communication sheet on dialysis days.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 record review, observation and staff interview, the facility failed to provide proper incontinent care and nail care to 2 (Residents # 198 & # 123) of 3 sampled residents who needed extensive assistance or were dependent on the staff for activities of daily living (ADL). Findings included: 1. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and needed extensive assistance with toilet use and personal hygiene. The assessment also indicated that the resident was always incontinent of bowels and had an indwelling urinary catheter. The facility's policy on perineal/incontinent care dated 2/12/12 was reviewed. The policy read in part " Use one hand to grasp edge of washcloth or wipe. Using second hand, separate the labia	F 312	F 312 F 312 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident #198 received appropriate incontinent care Resident #123 received nail care. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 25, 2014 residents dependent on staff for incontinent care were checked by Unit Managers / Unit	10/20/14

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F 312	Continued From page 15 and wash using disposable wipes, using clean wipe for each side and then another for the middle, always using downward strokes. Dispose of the wipe and obtain a new disposable wipe, wash groin on the outside of the labia from the front to the back starting outside the labia and then going to the inside of the thighs. " On 9/24/14 at 10:50 AM, Resident #198 was observed during the incontinent care. The resident had a large bowel movement on the disposable brief and a small amount on her hospital gown. While the resident was turned to her left side, Nurse #3 provided incontinent care by cleaning the buttocks/rectal areas using disposable wipes. After the incontinent care, Nurse #3 proceeded to change the dressing on the stage IV sacral decubitus ulcer. After the dressing change, Nurse #3 was about to apply a clean disposable brief to the resident. When asked if she would clean the perineal area before applying the clean brief, she replied " oh yeah. " Nurse #3 was observed to turn the resident to her back and cleaned the thighs with disposable wipes. The thighs were observed to have feces. Then, a clean disposable brief was applied. Nurse #3 was not observed to clean the perineal area/meatus of the resident. On 9/24/14 at 3:20 PM, the facility's policy on perineal/incontinent care was shared with Nurse #3. Nurse #3 had acknowledged that she did not provide proper incontinent care to the resident. 2. Resident #123 was admitted to the facility on 12/23/11. Cumulative diagnoses included: CVA (cerebrovascular accident) with hemiplegia (partial paralysis) on the non-dominant side and Dementia with behaviors.	F 312	Coordinators as it relates to completion of incontinent care. Appropriate incontinent care was provided to dependant residents. On September 25, 2014 all resident□s nail status was checked by Unit Managers / Unit Coordinators as it relates to completion of nail care for dependant residents. Nail care was provided to dependant residents. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education for all nursing staff began by Staff Development Coordinator and / or Director of Nursing on expectation of care for dependant residents as it relates to incontinent care and nail care. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will complete incontinent care observations on 10% of resident census per day. Observations will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. Observations will include off shifts and weekends. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will perform nail care audits on 10% of resident census per day. Audits will be done daily x 2 weeks, weekly x 4 weeks,	

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F 312	Continued From page 16 An annual Minimum Data Set (MDS) dated 8/25/14 indicated Resident #123 had short term and long term memory impairment and was moderately impaired in decision-making. Physical behavior symptoms directed towards others was noted as to have occurred 1--3 days and rejection of care occurred 1-3 days during the assessment period. Resident #123 required extensive assistance with personal hygiene and bathing. A care plan dated 8/29/14 indicated Resident #123 required staff assistance for most ADL's (activities of daily living) due to dementia and cognitive deficits. Approaches included: Give verbal cues to help prompt. Break tasks up into smaller steps. Allow rest breaks between tasks. One person to assist with bed mobility, transfers, walking, bathing, etc. A care plan dated 8/29/14 indicated Resident #123 was resistant to daily care most days. Approaches included: Approach slowly and calmly. Strike up a conversation before starting care and, if combative and resistive to care, leave and try to approach later. On 9/22/14 at 3:46 PM, an observation of Resident #123 revealed the fingernails on her right hand and the thumb nail on her left hand were elongated extending approximately ½ inch above the fingertips. Black material was noted under all the fingernails. On 9/23/14 at 10:21 AM, Resident #123 was observed sitting in her room in her wheelchair. The fingernails on her right hand and the thumb nail on her left hand were elongated approximately ½ inch above the fingertips and	F 312	then monthly x 4 months. Observations will include off shifts and weekends. The Director of Nursing will review incontinent care observations daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review nail care audits daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the incontinent care observations and nail care audit review to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 20, 2014	

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F 312	Continued From page 17	F 312		

black material was noted under all the nails. Resident #123 kept the fingers on her left hand clenched into her palm so observation of those fingers could not be obtained.

On 9/24/14 at 9:37 AM, Resident #123 was observed sitting in her room in her wheelchair. Her left hand was clenched with the fingers not visible. The fingernails on her right hand and the thumb nail on her left hand were elongated approximately ½ inch above the fingertips. Brown/ black material was noted under her nails.

On 9/24/14 at 4:00 PM, an observation was conducted and revealed Resident #123's nails remained elongated approximately ½ inch above the fingertips. Brown/ black material was noted under her nails.

On 9/25/14 at 7:28 AM, ADL (activities of daily care) was observed. NA (nursing assistant) #3 bathed resident, performed oral care and combed Resident #123's hair. Resident #123 did not resist care. NA #3 completed her care and transported Resident #123 to the dining room. NA #3 stated AM (ADL) care included bathing, oral care, combing the hair, applying lotion, dressing the resident and fingernail care. She acknowledged she did not perform nail care for Resident #123 and that the fingernails were too long. NA #3 stated the black material under her nails was due to Resident #123 scratching her head and she got the black hair dye under her nails. NA#3 also said Resident #123's daughter did not want her mother's nails cut but wanted them filed down and the daughter usually assisted with nail care

On 9/25/14 at 8:21 AM, Administrative staff #1

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F 312	Continued From page 18 stated she expected nursing staff to clean under the fingernails daily with an orange stick as part of morning care. Administrative staff #1 stated Resident #123's daughter did not want them to cut the nails but to file them down and wanted the nails to be clean.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide proper catheter care and failed to secure the indwelling urinary catheter tubing in place for 1 (Resident #198)of 3 sampled residents with an indwelling urinary catheter. Findings included: 1 a. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and had an indwelling urinary catheter. The comprehensive care plan was reviewed. There was no care plan to address the use of the indwelling catheter.	F 315	F 315 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident # 198 received appropriate catheter care. Resident # 198 has catheter tubing secured. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	10/20/14

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F 315	Continued From page 19 The facility's policy on catheter care (undated) was reviewed. The policy read in part " be certain that tubing is secured, without kinks and the drainage bag is below the level of the bladder but not resting on or dragging on the floor. " On 9/23/14 at 4:40 PM and 9/24/14 at 10:55 AM, Resident #198 was observed in bed with an indwelling catheter in place. The catheter tubing was observed not secured with a leg strap. On 9/24/14 at 11:05 AM, Nurse #3 was interviewed. She stated that catheter tubing should have been secured with a leg strap. She didn't know why Resident #198's catheter tubing was not secured. On 9/24/14 at 4:25 PM, Nurse #2 was interviewed. She stated that NAs were supposed to be checking the leg strap during care and inform the nurse if needed. She added that she was just informed about it. 1 b. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and had an indwelling urinary catheter The comprehensive care plan was reviewed. There was no care plan to address the use of the indwelling catheter. The facility's policy on catheter care (undated) was reviewed. The policy read in part " provide catheter care daily and as indicated after defecation or bowel movement. Wash area around urethral meatus with soapy cloth. Wipe from meatus down catheter, paying particular attention to any crusted areas. Remove any	F 315	On September 24, 2014 the Unit Manager / Unit Coordinator reviewed all residents with foley catheters to include completion of catheter care and securing of catheter tubing. Residents were provided appropriate catheter care and catheter tubing was secured. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education began by Staff Development Coordinator and / or Director of Nursing on expectation of foley care to include securing of catheter tubing. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will complete foley care observations to include securing of catheter tubing on residents with foley catheters daily. Observations will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. The Director of Nursing will review foley care observations daily to include securing of catheter tubing for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for	

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F 315	Continued From page 20 debris. " The facility's policy on perineal/incontinent care on a female resident with a urinary catheter dated 2/12/12 was reviewed. The policy read in part " grasp the catheter at the insertion site to eliminate pulling on the catheter and with a disposable wipe wash the catheter starting at the urinary opening to about 4 inches away from the body. " On 7/24/14, there was physician's order to insert an indwelling catheter to Resident #198 to promote wound healing to stage IV sacral decubitus ulcer. On 9/24/14 at 10:50 AM, Resident #198 was observed during the incontinent care. The resident had a large bowel movement on the disposable brief and a small amount on her hospital gown. While the resident was turned to her left side, Nurse #3 provided incontinent care by cleaning the buttocks/rectal areas using disposable wipes. After the incontinent care, Nurse #3 proceeded to change the dressing on the stage IV sacral decubitus ulcer. After the dressing change, Nurse #3 was about to apply a clean disposable brief to the resident. When asked if she normally clean the perineal area she stated " oh yeah. " Nurse #3 was observed to turn the resident to her back and cleaned the thighs with disposable wipes. The thighs were observed to have feces. Then a clean disposable brief was applied. Nurse #3 was not observed to clean the perineal area/meatus or to clean the catheter tubing. On 9/24/14 at 3:20 PM, the facility's policy on catheter care was shared with Nurse #3. Nurse #3 had acknowledged that she did not provide the	F 315	ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the incontinent care observations and nail care audit review to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of completion: October 20, 2014	

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F 315	Continued From page 21 proper incontinent and catheter care to the resident.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide the contracture management as ordered for 3 (Residents # 198, # 37 & # 123) of 4 sampled residents with limitation in range of motion. Findings included: 1. Resident #198 was admitted to the facility on 7/22/14 with multiple diagnoses including Senile Dementia and joint contracture. The admission Minimum Data Set (MDS) assessment dated 8/5/14 indicated that Resident #198 had severe cognitive impairment and had limitation in range of motion on one side. The occupational therapy (OT) notes dated 7/23/14 indicated that Resident #198 had " pain in left upper extremity from previous cerebrovascular accident (CVA) which limits passive range of motion to left upper extremity. Left hand contracted at wrist and proximal interphalangeal/distal interphalangeal joints with poor hygiene noted. Therapist performed hand hygiene to prevent skin breakdown to left hand.	F 318	F 318 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: Resident # 198, #37 and #123 have splints in place in place per physician order. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 26, 2014 residents with physician orders for splinting were reviewed. Orders for splinting were placed on the resident Medication Administration Record requiring the licensed nurse to ensure splint in place and/or place the splint per physician□s orders.	10/20/14

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F 318	Continued From page 22 Will assess need for left hand splint. " On 8/25/14, OT services were discontinued as Resident #198 had reached her maximum potential and had recommended to apply a cushion to the resident's left finger contracture. The physician's order dated 8/25/14 revealed " patient to wear left finger contracture cushion x (times) 6 hours except for hygiene and to be donned/doffed by nursing staff. " On 9/23/14 at 10:50 AM and 9/24/14 at 3:18 PM, Resident #198 was observed. Her left hand was contracted and there was no contracture management device noted. On 9/24/14 at 3:30 PM, NA #1 was interviewed. She stated that she had been working at the facility for seven years and she had not seen Resident #198 wearing a splint or cushion on her left hand. On 9/24/14 at 4:14 PM, Nurse # 2 was interviewed. She stated that she was the nurse for Resident #198 on 7-3 shift and she had not seen her wearing a splint or cushion on her left hand. She added that if she was on a splint or any device, it should have been written on the Medication Administration Record (MAR) for the nurses to apply but it was not on the MAR. On 9/24/14 at 4:49 PM, Nurse #1 was interviewed. She stated that she was the nurse of Resident #198 on 3-11 shift. She indicated that she had not seen the resident wearing a splint or a cushion on her left hand. On 9/24/14 at 5:45 PM, Nurse Manager #1 was interviewed. She stated that Resident #198 had an order for the left hand contracture cushion on	F 318	Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education began by the Staff Development Coordinator and / or Director of Nursing for nursing staff in reference to expectation for splint application and documentation of splint application. The Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will review Medication Administration Records in coordination with rounds to ensure that splinting is completed and documented per physician orders daily x 2 weeks, weekly x 4 weeks then monthly x 4 months. The Director of Nursing will review Medication Administration Record Audits daily for compliance. Review will be done daily x 2 weeks, weekly x 4 weeks, then monthly x 4 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present the findings of the Medication Administration Record audits as it relates to splinting to the Quality Assurance and Performance	

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F 318	Continued From page 23 8/25/14 but the order was not transcribed to the MARs for August and September, 2014 for nursing to apply and therefore it was not provided to the resident. 2. Resident #123 was admitted to the facility on 12/23/11. Cumulative diagnoses included: cerebrovascular accident (CVA) with hemiplegia on the non-dominant side. A rehabilitation department referral/ screen dated 6/4/14 stated changes in ROM (range of motion) UE (upper extremity) (splints). Restorative nursing reported Resident #123 was noncompliant and combative when attempts were made to apply her splint (right hand splint). Restorative nursing instructed to continue to apply splint as resident tolerated. Nursing notes were reviewed and documentation was noted that Resident #123 refused the left hand splint on 8/21/14. An annual Minimum Data Set (MDS) dated 8/25/14 indicated Resident #123 had short term and long term memory impairment and was moderately impaired in decision-making. She required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing. The assessment documented limited range of motion on one side for the upper extremities. Physician orders for September 2014 were reviewed and revealed a physician's order for Resident #123 to wear left resting hand splint when up in w/c (wheelchair) during the day. Splint to be removed for hygiene and when returning to bed for the night. OT (occupational	F 318	Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion: October 20, 2014.	

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therapy clarification: due to non-compliance, staff to apply splint as Resident #123 tolerated wearing.

An observation was conducted on 9/23/14 at 10:00 AM. Resident #123 was sitting in her wheelchair in her room. Her left hand was clenched. She was not wearing a left hand splint.

An observation was conducted on 9/24/14 at 9:39 AM. Resident #123 was sitting in her wheelchair in her room. Her left hand was clenched. She was not wearing a left hand splint.

On 9/24/14 at 3:51 PM, Resident #123 was observed sitting in her wheelchair in the dining room. Her left hand was clenched. She was not wearing a left hand splint.

The restorative nursing documentation for September 2014 was reviewed and no restorative documentation for 9/1-9/8, 9/12-16, 9/17, 9/19, 9/21-22, and 9/24.

On 9/25/14 at 9:24 AM, Administrative staff #2 stated sometimes the restorative aides were pulled off their restorative duties and put on the floor to work as a nursing assistant. She was unsure how often this occurred. She stated the restorative aides did not report back to her when they were pulled from their restorative duties. Administrative staff #2 stated she expected the nursing staff to do the range of motion exercises and apply splints when the restorative aides were pulled to the floor. She said the nursing staff was not notified when the restorative aide was pulled to the floor and that the nursing staff should observe that the splint was not placed on the resident and put the splint on themselves.

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F 318	Continued From page 25 On 9/25/14 at 10:07 AM, the occupational therapist stated the last referral/ screen for Resident #123 regarding the left hand splint occurred on 6/13/14. The recommendation at that time was for restorative to continue to try to apply if the patient tolerated. On 9/25/14 at 10:25 AM, restorative nursing aide (RA) #1 stated she was pulled off her restorative duties approximately two times a month. She stated she did not let Administrative staff #2 know that she had been pulled to work as a nursing assistant on the floor. She stated the unit manager was aware and believed that the unit manager told Administrative staff #2. 3. Resident #37 was admitted to the facility on 8/30/04 and readmitted on 2/15/11 with multiple diagnoses including multiple sclerosis, contracture of the hand, abnormal posture and dysphagia. A review of the Minimum Data Set (MDS) dated 9/3/14 was conducted. Resident #37 was assessed as having severe cognitive impairment. The MDS indicated the resident was assessed as having functional limitation in range of motion of the upper extremities on both sides of her body. A review of the Restorative Nursing Program Care Plan for Resident #37 was conducted. The plan of care dated August 2014 and September 2014 indicated the resident was to have a splint applied to her left hand and to wear the splint for six hours a day. A review of the care plans for Resident #37 was conducted. The plan of care dated 9/8/14	F 318		

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indicated the resident required assistance with her splints. The interventions included to teach the resident the correct application of the splint and to assist her with the application according to the scheduled wearing time.

A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day. "

A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/18/14, 8/19/14, 8/23/14, 8/24/14, 8/25/14, 8/26/14, 8/28/14, 8/29/14, and 8/31/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014.

A review of the Restorative Roster for the month of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3/14, 9/4/14, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014.

On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand.

On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left hand.

On 9/24/14 at 5:30 PM the resident was observed

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sitting in her wheelchair in the dayroom without a splint device on her left hand.

An interview was conducted with Administrative Staff #2 on 9/25/14 at 9:24 AM. She stated one restorative aide was expected to work six days per week, not including Sunday. She stated, at times, the restorative aide had been removed from her duties in restorative nursing and instructed to work as a nurse aide (NA) on a resident hall. She stated she was unaware of how often the restorative aide was instructed to work as a NA because she did not report back to her when it occurred. Administrative Staff #2 stated the nurses on the resident halls were expected to place the left hand splint on Resident #37 when the restorative aide was removed from her restorative nursing duties. She stated when the nurses observed that the resident's splint was not in place, they should have applied the splint. She stated the nursing staff was not notified when the restorative aide was removed from her duties in restorative nursing. She also stated the restorative aide was expected to document splint placement on the Restorative Nursing Program Flow Record. The restorative aide was expected to document if the resident refused to have a splint placed on the Restorative Nursing Program Flow Record.

An interview was conducted with Restorative Aide #1 on 9/25/14 at 10:25 AM. Restorative Aide #1 stated she had been pulled from her restorative nursing duties and instructed to work as a NA on a resident hall approximately two times a month. She stated she did not notify Administrative Staff #2 when she was removed from her duties in restorative nursing. She stated Resident #37 has never refused to allow placement of her left hand

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F 318	Continued From page 28 splint. She stated if a resident refused to allow splint placement, the restorative aide was expected to document the refusal on the flow record and to notify the hall nurse. She stated the restorative aide works Monday through Saturday. An interview was conducted with Administrative Staff #1 on 9/25/14 at 9:10 AM. Administrative Staff #1 stated the nursing staff was expected to place the left arm splint on Resident #37 when it was not applied by the restorative aide.	F 318		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		10/20/14

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F 431	Continued From page 29 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 record review, observation and staff interview, the facility failed to discard expired insulin vial and failed to date the medications (insulin (used to treat diabetes mellitus) and pulmicort (used to treat asthma attacks)) when opened. Findings included: The manufacturers' specification for pulmicort respule revealed " pulmicort respule ampules can be stored for 2 weeks after opening the protective aluminum foil envelope. Throw away pulmicort respules ampules if not used within 2 weeks of opening the protective foil envelope. " The facility's policy on " medication storage in the facility " dated 1/20/14 was reviewed. The policy read in part " the following guidelines should be followed for expiration dates for open multi-dose medications: Insulin was good for 28 days and pulmicort respule was good for 2 weeks once aluminum package was opened. " 1. On 9/25/14 at 1:20 PM, medication cart #1 on 300/400 hall was observed. An opened Lantus vial with an expiration date of 9/21/14 and an opened vial of Novolog mixed 70/30 undated	F 431	F 431 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: On September 25, 2014 one expired vial of Lantus and one undated vial of Novolog 70/30 were removed and discarded from medication cart one for 300/400 halls. On September 25, 2014 three boxes of undated Pulmicort respules were removed and discarded from medication cart two from the 300/400 halls. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 25, 2014 Unit Manager / Unit Coordinator checked all medication carts to ensure all expired medications had been removed and all opened vials of insulin and Pulmicort respules were dated when opened.	

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F 431	Continued From page 30 were observed on medication cart #1. On 9/25/14 at 1:25 PM, Nurse #4 was interviewed. She acknowledged that the opened Lantus vial was expired and was observed to discard it. She added that the nurse who first open the Novolog should have dated it. 2. On 9/25/14 at 1:45 PM, medication cart #2 on 300/400 hall was observed. Three boxes of pulmicort respules were observed with opened aluminum foil packages. The three opened aluminum foil packages had no date as to when they were opened. The first opened foil had 3 ampules, second had 3 ampules and the third had 4 ampules left. On 9/25/14 at 1:45 PM, Nurse #2 was interviewed. She indicated that she didn't know that pulmicort respules were good for 2 weeks once opened.	F 431	Measures put into place or systemic changes made to ensure that the deficient practice will not occur: On September 26, 2014 education began by the Staff Development Coordinator and / or Director of Nursing with licensed nurses on dating multi use vials and Pulmicort respules when opened and review of expiration dates prior to administration of medications. Unit Manager / Unit Coordinator, Nursing Supervisor, Staff Development Coordinator and / or Director of Nursing will check all medication carts daily to ensure all multi use vials and Pulmicort respules are dated when opened and expired medications are removed from medication carts. Medication cart checks will be completed daily x 2 weeks then weekly thereafter. The Director of Nursing will review results of medication cart checks daily x 2 weeks, weekly x 4 weeks, and monthly x 4 months. Facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained: The Director of Nursing will present findings of the daily medication cart checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of	

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F 431	Continued From page 31	F 431	compliance is obtained. Date of completion: October 20, 2014	