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	345304	A. BUILDING _____ B. WING _____	C 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An amended Statement of Deficiencies was provided to the facility on 03/09/15 because of the results of the Informal Dispute Resolution (IDR) process with the survey team deciding to delete tag F-514. Event ID# S3RN11.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156		2/20/15

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

Electronically Signed | 02/11/2015

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the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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F 156	Continued From page 2 The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews with facility staff, the facility failed to include the correct telephone number for the Complaint Intake Unit of the Division of Health Service Regulation in the facility's postings. Findings included: During an observation on 01/13/15 at 1:45 PM it was noted that the telephone number for the Complaint Intake Unit for the Division of Health Service Regulation was listed as 919-855-4555. This number is the Nursing Home Licensure & Certification Section Chief direct office number. The Complaint Intake Unit telephone number is 1-800-624-3004. An interview on 01/14/15 at 3:00 PM with the resident council president revealed that she was aware of how to file a complaint using the local ombudsman number. She was unaware of the number for the Complaint Intake Unit, Division of Health Service Regulation. She further revealed she did not know where the facility posted the numbers to file a complaint.	F 156	Brian Center Shamrock acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents. The Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted the week of January 12-16, 2015. Brian Center Shamrock□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Shamrock reserves the right to refute any deficiency on this Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures.	

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F 156	Continued From page 3 An interview with the medical record coordinator on 01/14/15 at 5:00 PM confirmed that the form listed in the bulletin board was the facility posting for resident purposes. She confirmed that the posted notification was to inform the residents of telephone numbers that they could use to file a complaint with the State Survey Agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.	F 156	F156: Notice of Rights, Rules, Services, Charges Criteria 1: Upon identifying the posted compliant intake number was incorrect, the administrator updated the resident information board on 1/15/2015. The number that was posted did connect directly to the NC Licensure and Certification office. Criteria 2: Administrator updated admissions packet to include a signed acknowledgment receipt of the Complaint Intake Unit information on 2/3/2015. Administrator will also update residents about the Complaint Intake information during her monthly Hot Topic Discussion with the residents on 2/11/2015. Mailed Notifications will be sent to responsible parties unable to participate in the Hot Top Discussions. 2/20/2015. Criteria 3: Administrator will monitor Resident Right Receipts for all admissions and verify the Complaint Intake Unit number is visible and in the correct location weekly for three months to ensure that compliance is obtained. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance	

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F 156	Continued From page 4	F 156	Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		2/20/15

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F 272	Continued From page 5 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct a comprehensive resident assessment for 5 of 17 sampled residents (Residents #79, 83, 75, 49, and 11). The findings included: 1. Resident #79 was admitted to the facility on 11/14/12 with diagnoses which included Alzheimer's Disease. Review of Resident #79's annual Minimum Data set dated 08/21/14 revealed an assessment of severely impaired cognition. The MDS indicated Resident #79 required the extensive assistance of 2 persons with transfer and the extensive assistance of one person with bed mobility, dressing eating and personal hygiene. The MDS indicated Resident #79 was always incontinent of urine and bowel. The MDS triggered Care Area Assessments (CAA) in the areas of communication, urinary incontinence, falls, pressure ulcer, and psychotropic drug use. The	F 272	Criteria 1: The RCMD or MDS Coordinator will modify and correct the CAAs associated with the most recent MDS assessments for Residents #79, #83, #75, #49, and #11 by 2/10/2015. Criteria 2: The RCMD or DDCM will complete an audit of residents receiving a Comprehensive MDS assessment during the last 30 days to verify accurate CAA completion per the RAI manual guidelines. Corrections will be made manually to each CAA as opportunities are identified. This audit will be completed by 2/20/2015 Criteria 3: The RCMC and Administrator will re-educate the IDT members on accurate CAA completion per RAI manual guidelines by 2/20/2015. The RCMD will	

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F 272	Continued From page 6 CAA of activities of daily living (ADL) did not trigger. Review of the CAAs revealed the following: · Communication documented dementia impacted communication. · Urinary continence documented a risk for infection. · Falls documented a risk for falls due to cognition, side effects of medications, renal insufficiency and use of wheelchair. · Pressure ulcer documented a risk for skin breakdown related to decreased mobility and wheelchair with presence of shearing. · Psychotropic drug use documented "see falls CAA." Further review of the CAAs revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #79. The CAAs did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with the MDS Coordinator on 01/16/15 at 9:17 AM revealed the CAA for ADLs should trigger for Resident #79. The MDS Coordinator reported Resident #79 did not receive a comprehensive assessment for ADLs. Interview with the Resident Care Manager on 01/16/15 at 9:20 AM revealed the software program used for the MDS could be a reason the ADL CAA did not trigger. The Resident Care Manager reported Resident #79 should have been assessed in the ADL CAA. A second interview on 01/16/15 at 3:35 PM with	F 272	randomly monitor 5 Comprehensive MDS assessments per week for 12 weeks to verify accurate CAA completion per the RAI manual guidelines. Opportunities will be corrected as identified. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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the MDS Coordinator revealed she was not aware the CAAs required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan.

A second interview on 01/16/15 at 3:40 PM with the Resident Care Management Director revealed the Care Area Assessments required a documented and detailed analysis.

2. Resident #83 was admitted to the facility on 02/24/14 with diagnoses which included cerebral vascular accident and congestive heart failure.

Review of Resident #83's admission Minimum Data Set (MDS) dated 03/03/14 revealed an assessment of intact cognition. The MDS indicated Resident #83 walked independently and required the limited assistance of one person with dressing, eating and personal hygiene. The MDS indicated Resident #83 was occasionally incontinent of urine. The MDS triggered the Care Area Assessments (CAA) in the areas of visual function, activities of daily living, urinary incontinence, falls, pressure ulcer and psychotropic drug use.

Review of the CAAs revealed the following:
· Visual function documented the presence of a missing right eye.
· ADLs documented Resident #83 required the assistance of staff.
· Urinary incontinence documented a risk for infection.
· Falls documented a risk for falls due to hypnotic use, impaired vision and wheelchair use.
· Pressure ulcer documented "see urinary incontinence CAA."
· Psychotropic drug use documented "see falls

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CAA."

Further review of the CAAs revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #83. The CAAs did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

Interview on 01/16/15 at 3:35 PM with the Minimum Data Set Coordinator revealed she was not aware the CAAs required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan.

Interview on 01/16/15 at 3:40 PM with the Resident Care Management Director revealed the Care Area Assessments required a documented and detailed analysis.

3. Resident #75 was admitted to the facility on 12/05/14 with diagnoses including cellulitis to both legs and diabetes mellitus (DM). The most recent admission Minimum Data Set (MDS) dated 12/12/14 revealed the resident with severely impaired cognition. He required extensive 1 to 2 person assistance with activities of daily living (ADL). The resident was frequently incontinent of both bowel and bladder. His nutritional assessment noted a height of 70 inches, a weight of 173 pounds and the resident as receiving a therapeutic diet. No pressure ulcers or stasis ulcers were noted on his skin assessment with Resident #75 having in place pressure reduction devices for his bed and chair. The resident was noted as taking antibiotic medication for the full 7 day MDS assessment period. The MDS triggered the following care areas as noted in the Care

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Area Assessment (CAA) summary: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status and Pressure Ulcer.

Review of Resident #75's CAA Review Report revealed the following in Analysis of Findings: for the Care Area of Nutritional Status "the resident is potential for weight loss [related to] therapeutic diet due to [diagnosis] of DM." For the Care Area of Pressure Ulcer "the resident is potential for pressure ulcer development [related to] impaired bed mobility and bowel incontinent due to functional loss."

Further review of the CAAs revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #75. The CAAs did not document an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

An interview on 01/16/15 at 3:35 PM with the MDS Coordinator revealed she was not aware the CAAs required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan.

An interview on 01/16/15 at 3:40 PM with the Resident Care Management Director revealed the CAAs required a documented and detailed analysis.

4. Resident #49 was admitted to the facility on 12/12/08 with diagnoses including history of cerebrovascular accident (CVA), Diabetes Mellitus (DM) and congestive heart failure. The most recent annual Minimum Data Set (MDS)

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dated 11/26/14 revealed the resident as wearing hearing aids, having clear speech and usually understanding others and being understood. He was coded as having severely impaired cognition. Resident #49 was coded as requiring extensive 2 person assistance with all activities of daily living (ADL) and as always being incontinent of both bowel and bladder. He was noted to be 70 inches in height, 140 pounds and receiving a therapeutic/mechanically altered diet. The MDS triggered the following care areas as noted in the Care Area Assessment (CAA) summary: Cognitive Loss/Dementia, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status and Pressure Ulcer.

Review of Resident #49's CAA Review Report revealed the following in Analysis of Findings for all triggered care areas: "resident alert and oriented to self only has poor short and long term memory is able to communicate needs to staff appropriately has [history] of CVA and [diagnosis] of dementia has had frequent [incontinence] of bowel and bladder staff will provide [extensive] assist with transfer and mobility has risk for falls due to confusion and possible effects from medications has generalized weakness receives [mechanical] soft diet as ordered receives nutritional supplement for noted weight loss and has weekly weights as ordered no skin breakdown noted staff provides skin care daily and as needed."

Further review of the CAAs revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #49. The CAAs did not document an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.

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An interview on 01/16/15 at 3:35 PM with the MDS Coordinator revealed she was not aware the CAAs required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan.

An interview on 01/16/15 at 3:40 PM with the Resident Care Management Director revealed the CAAs required a documented and detailed analysis.

5. Resident #11 was admitted to the facility on 03/29/14 with diagnoses including dementia, diabetes mellitus and abnormal posture. Review of the most recent annual Minimum Data Set (MDS) assessment dated 01/02/15 revealed the resident to have no speech, rarely or never being understood or to understand others, having long and short term memory problems and as having severely impaired cognition for daily living. Resident #11 was coded as requiring total 1 to 2 person assistance with all activities of daily living (ADL) and as always being incontinent of both bowel and bladder. The resident's height was noted as 57 inches, her weight as 121 pounds and as having a feeding tube. The MDS triggered the following care areas as noted in the Care Area Assessment (CAA) summary: Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Feeding Tube, Dehydration and Pressure Ulcer.

Review of Resident #11's CAA Review Report revealed the following in Analysis of Findings for triggered care areas: for Cognitive Loss/Dementia "resident has long and short term memory loss rarely makes decisions for self has [diagnosis] of altered mental status." For Urinary

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F 272	Continued From page 12 Incontinence and Indwelling Catheter "resident [incontinent] of bladder needs [extensive] assist with toileting is dependent for all care has altered mental status." For Falls "resident has weakness alert mental status is dependent for transfer and staff will provide assist as needed for transfer and mobility." For Nutritional Status "see dietary notes." For Feeding Tube "resident receives tube feeding as ordered see dietary notes." For Dehydration/Fluid Maintenance "no [signs or symptoms] of dehydration noted resident receives fluids via tube feeding as ordered." For Pressure Ulcer "resident has no pressure ulcer noted needs total assist with bed mobility has altered mental status." Further review of the CAAs revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #11. The CAAs did not document an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. An interview on 01/16/15 at 3:35 PM with the MDS Coordinator revealed she was not aware the CAAs required documentation of resident specific characteristics and risk factors used in analysis and the decision to proceed to care plan. An interview on 01/16/15 at 3:40 PM with the Resident Care Management Director revealed the CAAs required a documented and detailed analysis.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the	F 274		2/20/15

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F 274	Continued From page 13 facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to conduct a significant change assessment for 1 of 3 sampled residents who experienced a significant change (Resident #83). The findings included: Resident #83 was admitted to the facility on 02/24/14 with diagnoses which included cerebral vascular accident and congestive heart failure. Review of Resident #83's admission Minimum Data Set (MDS) dated 03/03/14 revealed an assessment of intact cognition. The MDS indicated Resident #83 walked independently and required the limited assistance of one person with dressing, eating and personal hygiene. The MDS indicated Resident #83 was occasionally incontinent of urine. Review of a hospital discharge summary revealed Resident #83 was hospitalized from 05/09/14 to	F 274	Criteria 1: Corrective action for this alleged deficient practice was satisfied by completing a Significant Change Assessment for resident #83 by 1/16/2015. Criteria 2: All residents who have had a change of condition are at risk for the same alleged deficient practice. The Resident Care Management Director or MDS Coordinator will complete an audit of all resident with an identified change of condition during the last 30 days to verify the appropriate Significant Change Assessment has been completed by 2/20/2015. Criteria 3: Measures put into place to prevent future deficient practice include: The Director of Nursing or RCMD will re-educate all Licensed Nurses completing the MDS on	

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F 274	Continued From page 14 05/19/14 for treatment of a right cerebellar and punctual parietal ischemic stroke. Review of Resident #83's quarterly MDS dated 05/27/14 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #83 required the assistance of one person to walk and the assistance of 2 persons with transfer. The MDS indicated Resident #83 required the extensive assistance of one person with dressing, eating and personal hygiene. The MDS indicated Resident #83 was always incontinent of bowel and coded other device for urine. Review of Resident #83's most recent quarterly MDS dated 10/26/14 revealed an assessment of severely impaired cognition. The MDS indicated Resident #83 did not walk, required total assistance with locomotion and the extensive assistance of one person with dressing, eating and personal hygiene. The MDS indicated Resident #83 was always incontinent of urine and bowel. Observation on 01/14/5 at 9:14 AM revealed Nurse Aide (NA) #1 transported Resident #83 in a wheelchair and used a facecloth to wipe spilled food off of his face. Interview with NA #1 on 01/14/15 at 9:16 AM revealed Resident #83 walked and ate independently upon admission but now required extensive assistance. Interview with the MDS Coordinator on 01/15/15 at 11:25 AM revealed the interdisciplinary team would identify the need for a significant change MDS and the Resident Care Management Director would make the decision. The MDS	F 274	the requirement for completion of Significant Change Assessment by 02/20/2015. The Resident Care Management Director will randomly review 5 residents with a change in condition weekly for 12 weeks to verify the appropriate Significant Change Assessment has been completed. Opportunities will be corrected as identified. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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F 274	Continued From page 15 Coordinator explained the change in Resident #83 had not been discussed. Interview with the Resident Care Management Director on 01/15/15 at 12:09 PM revealed a significant change MDS assessment should have been conducted with the change in level of assistance required, mobility, bowel and bladder status and decision making ability with the 05/27/14 assessment.	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews, and	F 280	Part 1:	2/20/15

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F 280	Continued From page 16 medical record reviews, the facility failed to update the care plan goal after a resident sustained falls with injury for 1 of 20 care plans reviewed (Resident #30) and failed to invite a resident or their family member to periodic care planning conferences for 1 of 5 residents reviewed (Resident #49). Findings included: 1. Resident #30 was admitted to the facility 11/22/10. Resident #30 was legally blind and diagnoses included bladder cancer, hearing loss, vascular dementia, recurrent stroke, and hemiplegia. A quarterly minimum data set (MDS) dated 08/18/14 assessed Resident #30 with impaired cognition and a history of falls. A care plan dated 08/18/14 identified Resident #30 at risk for falls related to poor ambulation, incontinence, poor vision, poor balance while standing/walking and use of a wheel chair. The goal of the care plan recorded that Resident #30 would be free of fall related injury through the next review in 90 days (November 2014). The care plan recorded the following falls with injury: · 09/30/14 09:15 AM, Resident #30 fell in his room and sustained a hematoma to his head · 10/22/14 3:30 PM, Resident #30 fell in his room, complained of pain, Xray results was "suspicious" for a pelvic fracture An interview with the director of nursing (DON) occurred on 01/15/15 at 11:45 AM. The interview revealed that at the time of a fall, the nurse should try to establish the root cause of the fall	F 280	Criteria 1: Resident #30 discharged from facility on 11/05/2015. Criteria 2: The Director of Nursing and Assistant Director of Nursing will conduct a review of all residents who have frequent skin tears and/or have sustained 2 or more falls in the past 90 days to ensure appropriate plan of care and interventions have been implemented by 2/20/2015. Criteria 3: The Director of Nursing or Staff Development Nurse will provide re education to all Resident Care Specialist and Licensed Nurses on the Falls Management Policy and implementation of care planned interventions will be completed 2/20/15. The DON and ADON will review residents with repeat incidents weekly through the facilities At Risk Meeting to validate effectiveness of implemented interventions. The IDT will round will be done 3x a week for 4 weeks, then 2 times a week for 8 weeks to verify interventions are in place for accident prevention. Opportunities will be corrected as identified. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any	

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F 280	Continued From page 17 and implement interventions. A committee of staff (DON, assistant director of nursing (ADON), unit managers, activity director, and therapy manager) meet the next business morning to review the fall and interventions for effectiveness. The DON stated that additional interventions were added during this meeting, if necessary, and the care plan was reviewed and updated. The DON further stated that there were incidents that occurred in which a committee review of the incident may not have been done consistently. An interview with the ADON occurred on 01/16/15 at 4:17 PM. The ADON stated that a falls committee met each morning after a resident fell to determine the possible cause of the fall, make therapy referrals, notify the physician of a change in condition, order blood work/labs as needed and update the care plan and nurse aide care sheets. The ADON further stated that the committee also discussed the care plan goal for possible revision. A follow up interview with the ADON on 01/16/15 at 7:00 PM revealed that Resident #30's care plan goal should have been revised. She further stated that the falls committee would have to do a better job going forward reviewing and revising care plans goals. The interview also revealed that the facility's quality assurance (QA) committee reviewed falls during the October - December 2014 meetings and noted a decrease in falls for each of these months. The ADON stated that the QA committee planned to discuss a system for monitoring the QA interventions related in falls in January 2015 meeting which has not yet occurred. 2. Resident #49 was admitted to the facility on 12/12/08 with diagnoses including a history of stroke, congestive heart failure and diabetes	F 280	items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved. Part 2: Criteria 1: Upon identifying the interest of the family member of resident #49, the family member was contacted on 1/16/2015 by the new Social Services Director and inquired about any concerns that the family member may have had. Concerns were documented and followed up on as well as communicated to the interested family member on 1/20/2015 and 1/26/2015. Criteria 2: Administrator re- educated IDT on 1/16/2015 about notification of the resident and any interested family member. Audit will be conducted by Administrator, Director of Nursing, and Social Services Director to identify any interested family member by 2/20/2015. SSD verbally invites residents and interested parties as well as mail a written letter to both resident and interested parties. Criteria 3:	

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F 280	Continued From page 18 mellitus. Review of his most recent Minimum Data Set (MDS) assessment dated 11/26/14 revealed Resident #49 was usually understood, could usually understand others and had severely impaired cognition. The MDS noted the resident but not any family as participating in the assessment. Review of his care plan revealed the problem of depression, anxiety and sad mood dated 11/26/14 with the intervention "involve family information gathering to determine causative factors." Review of the admission face sheet dated 05/14/14 revealed family member #1 as the resident's emergency notification with the relationship and a telephone number noted. Resident #49 was noted as his own responsible person (RP) for billing and financial concerns and in the block labeled "responsibility/legal guardian" was noted the phrase "family member responsible." Review of a social progress note dated 05/28/14 revealed the social service director (SSD) spoke with family member #1 documented this person was willing to participate in care plan meetings. Review of an interdisciplinary care conference attendance record form revealed check blocks for "resident attended?" and "family/representative attended?". An entry on this form dated 05/28/14 revealed the attendance status for Resident #49 or his family was not determined. Another social progress note dated 08/26/14 revealed the resident might require some assistance with some decisions. Review of an interdisciplinary care conference attendance record dated 09/03/14 revealed the attendance status for Resident #49 or his family was not determined. Review of a social progress note dated 11/26/14	F 280	Administrator will track invitation letters to resident and interested family members as well as status of participation weekly times 12 weeks. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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F 280	Continued From page 19	F 280		

revealed Resident #49 remained alert with unimpaired cognition. Review of an interdisciplinary care conference attendance record dated 12/02/14 revealed the attendance status of Resident #49 or his family was not determined.

A phone interview on 01/13/15 at 2:33 PM with family member #1 revealed she was the person notified with concerns involving Resident #49. She stated she spoke with the SSD once in 2014 but received no invitations to participate in care planning meetings.

An interview on 01/14/15 2:55 PM with Nurse #2 revealed family were notified when there was a change in condition or a transfer to hospital. She stated the person noted on the white admission sheet in the chart as the RP was called and if the resident was their own RP then family might be called depending on the resident's cognition level. She stated she had seen family member #1 visit Resident #49 in person at least twice and that although that person did not visit often, when the nurse had to call her in the past family member #1 would return phone calls or answer the phone.

Another phone interview on 01/15/15 at 9:28 AM with family member #1 revealed in April 2014 a hospital called her regarding replacement of a pacemaker battery for Resident #49 but the facility did not call her. She stated she called the facility to make sure the resident had come back from the hospital. She stated she received a call last year from a SSD, it was not about care planning but rather had to do with clothing. She stated she had received another call from a new SSD but there were no invitation to participate in a care plan conference. She stated she received

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F 280	Continued From page 20 a call from a nurse asking permission to give the resident an influenza vaccination which she provided. She stated when she last visited she observed Resident #49 put to bed earlier than his time of 8:00 PM, a time told to an SSD upon his admission and consistent with his practice when he was at home, and when she asked an unnamed nurse about this the family member was told the resident had a care plan to go to bed at a certain time. An interview on 01/15/15 at 7:27 PM with the assistant director of nursing (ADON) revealed resident preferences were determined upon admission, updated during care planning conferences and the care plan was updated to reflect preferences when they were changed. She stated family, if available, were invited to participate in care planning conferences. The administrator joined the interview and stated the current SSD was new in the past prior weeks and had personally scheduled the most recent conferences using the admission cover sheet for family contact information. The administrator stated a letter was sent by the SSD to family inviting them to these conferences. The administrator stated if family attended there was a place on the care planning conference record to document their attendance. Review of Resident #49's medical record by the administrator was performed and she stated a social progress note in May, 2014 documented that family wanted to be involved and family should have been invited to care planning conferences since that time.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		2/20/15

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F 323	Continued From page 21 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 observations, interviews with residents (#74 and 25), staff and a contracted plumber, review of medical records, facility records and a facility policy, the facility failed to 1) monitor water temperatures after repairs were completed to a pipe to maintain water temperatures in resident bathroom sinks in a safe range of 100-116 degrees Fahrenheit (F) for 10 of 28 sampled resident bathrooms (Rooms 101, 102, 103, 104, 201, 208, 214, 304, 305, and 313), as well as 2) supervise and implement care plan interventions for a resident with a history of falls resulting in 11 falls since April 2014 (Resident #30) and 3) did not apply geriatric sleeves or a long-sleeved shirt for a resident with bruises and a skin tear (Resident #83) for 2 of 4 sampled residents reviewed for supervision to prevent accidents. Findings included: 1. Review of the facility's policy for Monitoring Water Temperatures, dated June 2007, read in part, "Water temperatures are checked periodically to ensure the safety and welfare of residents and employees." "Procedures included: 1. Check hot water temperatures at both individual and common resident use areas. 2. Schedule sampling to check temperatures at a representative set of fixtures throughout the entire	F 323	Part 1: Criteria 1: Upon identifying high water temperatures on 1/12/2015, the mixing valve was immediately replaced and calibrated to 110 degrees to allow for flexibility in valve fluctuations. Temperatures were then taken after replacing the valve and reviewed by survey team to be within the required 100 degree to 116 degree range on 1/16/2015. Criteria 2: On 1/9/2015, facility shut water off to fix a pipe and when the water was turned back on, it was noted on 1/12/2015 that sediment had settled in the mixing valve causing more fluctuation. Administration decided on 1/12/2015 that as a best practice, water temperatures should be monitored after shutting water off to ensure that water temperatures are within the required range. Criteria 3: Maintenance Director or Manger on Duty will check facility water temperatures as followed: 2 resident areas per corridor three times	

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F 323	Continued From page 22 building every 3 days; sample problem areas daily. Rotate thru (through) the sets so that all fixtures are covered over a period of time." Observations of resident bathroom sink water temperatures occurred on 01/12/15 at 11:54 AM and revealed a hot water temperature that exceeded 116 degrees Fahrenheit (F) in room 214. The surveyor's digital thermometer displayed a reading of 32.3 degrees F when checked for calibration. An interview on 01/12/15 at 11:58 AM with nurse aide (NA) #1 who routinely worked on the 200 hall revealed the water came out of the faucet really hot at times. NA#1 explained the water routinely cooled down after it ran approximately 30 seconds to one minute. Review of an admission minimum data set, dated 10/23/14 for Resident #74, in room 113 revealed he had intact cognition. During an interview with Resident #74 on 01/12/15 at 12:06 PM, he revealed that the water came out of the bathroom sink hot at times and stated he was able to adjust it after it cooled down and ran for one minute. Resident #74 stated he used the water at the bathroom sink to wash his hands, face, and brush his teeth and for bathing. He did not report to staff that the water at the sink was hot because he stated he was able to add cold water for his comfort. An interview on 01/12/15 at 12:23 PM with NA #3 who routinely worked on the 300 hall revealed that the water in some resident's bathroom sinks on the 300 hall got too hot and required the addition of cold water to be comfortable for the resident. NA #3 stated she did not report this	F 323	daily for 4 weeks 1 resident area per corridor once daily for 8 weeks. Opportunities will be corrected as identified and reported to the Administrator. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved. Part 2: Criteria 1: Resident #30 was discharged from facility 11/05/2014. Criteria 2: The Director of Nursing and Assistant Director of Nursing will review 2/6/15 of all residents who have frequent skin tears and/or have sustained 2 or more falls in the past 90 days to ensure appropriate	

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F 323	Continued From page 23 because she was able to add cold water for the resident's comfort. On 01/12/15 at 2:40 PM, the maintenance director stated he was responsible for monitoring water temperatures. The maintenance director stated he monitored water temperatures daily, routinely between 6:00 AM - 7:00 AM by checking the water temperatures of resident rooms and shower rooms. He stated the facility had a frozen pipe that burst on 01/09/15 when it got cold and the water was turned off for approximately 4 hours while the repairs were made. He further stated he thought he last checked his digital thermometer for calibration 3 months ago. The maintenance director proceeded to check his thermometer for calibration and obtained a temperature of 37 degrees F. He stated his thermometer could not be used to check water temperatures because it would not give an accurate water temperature reading and he stated he did not have another thermometer for use. He further stated he typically allowed the water to run for approximately two minutes before checking the temperature. Review of the water temperature log from 07/01/14 - 01/07/15 revealed daily water monitoring was conducted by the maintenance director. No concerns were identified with water temperatures that exceeded 116 degrees F. There were no documented water temperatures for 01/09/15 - 01/12/15. The maintenance director was accompanied by surveyors to check water temperatures in residents bathroom sinks on 01/12/15. The maintenance director used the surveyor's digital thermometer to obtain the following water temperatures:	F 323	plan of care and interventions have been implemented. Criteria 3: Director of Nursing or Staff Development Nurse will reeducate all Resident Care Specialist and Licensed Nurses on Falls Management Policy and implementation of care planned interventions will be completed by 2/20/15. The Director of Nursing or Staff Development Nurse will provide re education to all Resident Care Specialist and Licensed Nurses on the Falls Management Policy and implementation of care planned interventions will be completed 2/20/15. The DON and ADON will review residents with repeat incidents weekly through the facilities At Risk Meeting to validate effectiveness of implemented interventions. The IDT will round will be done 3x a week for 4 weeks, then 2 times a week for 8 weeks to verify interventions are in place for accident prevention. Opportunities will be corrected as identified. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on	

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F 323	Continued From page 24 · At 2:46 PM, the bathroom sink in room 208 had a water temperature of 120.8 degrees F. · At 2:50 PM, the bathroom sink in room 201 had a water temperature of 122.2 degrees F. · At 2:58 PM, the bathroom sink in room 214 had a water temperature of 117.6 degrees F. · At 3:07 PM, the bathroom sink in room 313 had a water temperature of 118.3 degrees F. · At 3:15 PM, the bathroom sink in room 305 had a water temperature of 119 degrees F. · At 3:16 PM, the bathroom sink in room 304 had a water temperature of 124.7 degrees F. · At 3:19 PM, the bathroom sink shared between rooms 101 and 103 had a water temperature of 124.1 degrees F. · At 3:22 PM, the bathroom sink shared between rooms 102 and 104 had a water temperature of 121.1 degrees F. On 01/12/15 at 4:00 PM, during an interview with maintenance director, he stated the mixing valve gauge should be set at 120 degrees F to maintain safe water temperatures for resident's use in their bathrooms in a range of 100-116 degrees F. During an observation of the mixing valve gauge revealed a set temperature of 130 degrees F. The maintenance director stated he was responsible for monitoring the water temperature for the mixing valve but could not recall how often or the last time he checked the mixing valve water temperature gauge. On 01/12/15 at 4:45 PM during an interview with the maintenance director he stated a possible cause for the elevated water temperatures observed in resident bathroom sinks was sediment in the mixing valve. He reported that the mixing valve would be replaced immediately.	F 323	results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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Review of an admission minimum data set dated 12/18/14 for Resident #25, in room 302, revealed she had intact cognition. During an interview with Resident #25 on 01/13/15 at 9:33 AM, the Resident stated that staff added cold water in her bathroom sink for her because the hot water got "hot, hot, hot". She reported that she did not use the water at her bathroom sink independently.

An interview with the facility's contracted plumber occurred on 01/14/15 at 10:48 AM. The interview revealed that he repaired a pipe that burst due to freezing temperatures in the shower room on the 200 hall on 01/09/15. During the interview, he stated professional standards were to monitor water temperatures after completion of repairs.

During an interview on 01/16/15 at 5:13 PM the administrator stated that a Quality Assurance Performance Improvement (QAPI) review was started on 01/12/15 once she became aware of the hot water temperatures observed for resident's bathroom sinks. The administrator explained that she expected the maintenance director to check the temperature gauge for the mixing valve three times daily; he should check temperatures in two resident rooms per hall three times daily and document water temperatures according to the readings.

2. Resident #30 was admitted to the facility 11/22/10. Resident #30 was legally blind and diagnoses included fracture of patella, contusion injury of brain, depression, bladder cancer, hearing loss, vascular dementia, recurrent stroke, and hemiplegia.

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A quarterly minimum data set (MDS) dated 08/18/14 assessed Resident #30 with severely impaired cognition and a history of falls.

A care plan dated 08/18/14 identified Resident #30 at risk for falls related to poor ambulation, incontinence, poor vision, poor balance while standing/walking and use of a wheel chair. Care plan interventions included the use of chair and bed alarms, keep resident in view of staff, provide adaptive devices (elevated toilet seat/bedside commode) and a toileting program.

Review of the post fall reviews, incident reports, narcotic records and nurse's notes and interviews with staff revealed Resident #30 sustained the following falls.

· On 04/10/14 at 8:40 PM, Resident #30 stood up from his bed to go to the bathroom and fell. He was not injured. The post fall review and nurse's notes, documented that Resident #30 had an unwitnessed fall while wearing socks, unable to use a call light, and the lights were off as contributing factors to this fall. Staff applied a winged mattress and pressure sensitive pad alarm to his wheel chair as a post fall intervention.

An interview with the director of nursing (DON) on 01/15/15 at 11:45 AM and review of the incident report dated 04/10/14 revealed Resident #30 got out of bed too fast, his legs buckled, he fell and he hit his head on a door. Resident #30 reported to staff he was going to the bathroom. The DON stated she did not know what interventions were in place prior to this fall. She stated that after the fall Resident #30 was assisted to the bathroom, his call light was clipped to his nightgown and a

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winged mattress was added. The DON stated Resident #30 could use the call light, but just did not remember to do so; he required frequent staff checks. The DON stated the facility's follow-up to falls included that at the time of a fall, the nurse would attempt to establish the root cause of the fall and implement interventions. A committee of staff (DON, assistant director of nursing (ADON), unit managers, activity director, and therapy manager) met the next business morning to review the fall and interventions for effectiveness. The DON stated that additional interventions were added during this meeting, if necessary, and the care plan was reviewed and updated. The DON further stated that there were incidents that occurred in which a committee review of the incident was not done consistently and the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident.

An interview on 01/16/15 at 10:24 AM with nurse #6 revealed Resident #30 was found kneeling on the floor next to his bed on 04/10/14 after attempting to go to the bathroom unassisted. Nurse #6 stated Resident #30 would not remember to use the call light and could not follow simple instructions. Nurse #6 stated he often stood up unassisted, required frequent monitoring, propelled from hall to hall and was not easily redirected. Nurse #6 stated one to one monitoring worked for Resident #30 because "he fell a lot", so staff tried to keep him at the nurse's station to watch him.

An interview on 01/16/15 at 10:45 AM with nurse aide (NA) #4 revealed she worked with Resident #30 at times and she was the NA for Resident #30 when he fell on 04/10/14. NA #4 stated

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Resident #30 frequently got up unassisted trying to go to the bathroom; he was confused and required frequent orientation to his surroundings and frequent checks.

· On 06/23/14 at 9:00 PM, Resident #30 ambulated unassisted in his room, tried to sit on his bed and fell. He sustained a skin tear to his left upper extremity. The post fall review and nurse's notes documented the fall was unwitnessed and that Resident #30 had periods of increased anxiety as a contributing factor to the fall. A medication review with medication adjustments was completed as a post fall intervention.

On 01/15/15 at 11:56 AM, an interview with the DON revealed the incident report dated 06/23/14 did not document what interventions were in place at the time of the fall, but that a NA was entering his room when he fell. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident. The DON stated the NA assigned at the time of this fall no longer worked at the facility. Attempts to reach this NA were unsuccessful.

On 01/15/15 at 7:37 PM, nurse #7 stated she often worked with Resident #30 on the 3-11 PM shift and described him at high risk for falls due to confusion. She stated he propelled from room to room and was easily agitated. Nurse #7 stated she could not recall the specifics of the 06/23/14 fall, or if an alarm sounded, but recalled the fall interventions that were used for Resident #30 included a low bed, floor mats, and bed/chair alarms. Nurse #7 stated Resident #30 spent most of the time in bed on her shift or staff kept him at

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the nurse's station. Nurse #7 stated Resident #30 "fell all the time, at least once per week, he was always on the floor."

· On 07/14/14 (no time indicated), Resident #30 was found on the floor in his bathroom. The fall was unwitnessed, he was not injured. The post fall interventions included a bed/chair alarm.

On 01/15/15 at 12:06 PM an interview with the DON and review of the incident report dated 07/14/14 revealed Resident #30 was found on the bathroom floor at 8:30 PM. The DON stated the incident report did not indicate what fall interventions were in place at the time of the fall, but that a bed and chair alarm was added as post fall interventions. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident. The DON stated the NA assigned at the time of this fall no longer worked at the facility. Attempts to reach this NA were unsuccessful.

On 01/15/15 at 7:37 PM, nurse #7 stated she often worked with Resident #30 on the 3-11 PM shift and described him at high risk for falls due to confusion. She stated he propelled from room to room and was easily agitated. Nurse #7 stated she could not recall the specifics of the 07/14/14, or if an alarm sounded, but recalled the fall interventions that were used for Resident #30 included a low bed, floor mats, and bed/chair alarms. Nurse #7 stated Resident #30 spent most of the time in bed on her shift or staff kept him at the nurse's station. Nurse #7 stated Resident #30 "fell all the time, at least once per week, he was always on the floor."

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· On 07/18/14 at 10:00 AM, Resident #30 was observed to propel in the hallway towards the nurse's station, came upon a wet floor sign, tried to kick the sign and slid from the wheel chair to the floor. He was not injured. The post fall review indicated increased confusion as a contributing factor, but did not document the interventions in place at the time of the fall. The post fall intervention was for staff to assist Resident #30 around objects in the hallway.

On 01/15/15 at 9:30 AM, the DON stated this fall was observed by the floor tech. Review of the incident report dated 07/18/14 and interview with the DON revealed there was no documentation regarding what interventions were in place at the time of the fall. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident.

On 01/16/15 at 07:18 AM, nurse #8 stated she was the nurse assigned to work with Resident #30 primarily on the 11 PM -7 AM shift, but remembered she worked the morning he fell on 07/18/14. Nurse #8 stated Resident #30 had a tabs monitor in place as an intervention at the time of this fall, but could not recall the specifics of this fall or if the tabs monitor was in place. Nurse #8 stated Resident #30 was confused, had hearing loss, impaired vision and increased anxiety due to health decline. Nurse #8 stated he had lots of falls, required constant redirection due to short term memory deficits and he could not remember to use the call bell.

On 01/16/15 at 09:36 AM, floor tech #1 stated that on 07/18/14 he was setting up cones to start mopping when Resident #30 propelled down the

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hall towards the nurse's station and tried to kick one of the cones and slid out of his chair. Floor tech #1 stated he caught Resident #30 before he reached the floor. Floor tech #1 stated he remembered that Resident #30 was real agitated that morning and made several attempts to get out of bed unassisted. The floor tech #1 stated he could not be certain if Resident #30 had an alarm in place at the time of the incident.

· On 08/07/14 at 12:15 AM, Resident #30 was found seated on the floor in his room after an unwitnessed altercation with Resident #82. Resident #30 sustained bruises to both knees and left skull and complained of pain to his right lower side for which he received 1 milligram Hydrocodone 5-325 at 12:15 AM and 05:30 AM. He informed staff he was hit with a cane by Resident #82. Resident #30 was kept at the nurse's station to monitor until he was placed back in bed around 05:30 AM. Resident #30 was transferred to the hospital at the beginning of the 7-3 AM shift on 08/07/14 for further evaluation and diagnosed with a contusion (bruised area with swelling and pooling of blood underneath the skin) to his head. Post fall interventions included a referral for a psychological evaluation, medication review and roommate change.

On 01/15/15 at 3:05 PM the DON stated she was not the DON on 08/07/14, but started employment a few days later. The DON stated she was informed that a resident to resident altercation occurred on 08/07/14 and resulted in Resident #30 being hit with a cane and falling. The DON stated the post fall interventions for the fall that occurred on 08/07/14 included that Resident #30 was assessed at the time of the

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incident without significant injury and received pain medication; by the next morning nurse #3 assessed Resident #30 with pain, bruising and a knot to his head. Nurse #3 contacted the physician and obtained an order to transfer Resident #30 to the emergency room (ER). The DON stated both residents were confused and separated for the rest of the night. Resident #82 was monitored every 30 minutes for 24 hours. Both residents were referred for a psychological evaluation and a medication review. Resident #82 reported to staff that Resident #30 got in bed with him and urinated, so Resident #82 pushed him out of his bed and hit him with his cane. The DON stated the incident report did not document whether or not Resident #30's alarm sounded to alert staff. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident.

On 01/15/15 at 7:37 PM, nurse #7 stated she often worked with Resident #30. Nurse #7 described Resident #30 at high risk for falls due to confusion, propelled from room to room and was easily agitated. Nurse #7 stated she was the assigned nurse on the 11PM - 7 AM shift when Resident #30 fell on 08/07/14. Nurse #7 stated the fall occurred close to change of shift and it was unwitnessed. Nurse #7 stated she was alerted by a NA that Resident #30 was on the floor and had urinated in the bed of Resident #82. Resident #30 was assessed without injury or bruises, medicated for pain and kept at the nurse's station until early morning to monitor. Nurse #7 stated nurse #3 came in on the 7 AM - 3 PM shift, called the physician and obtained an order to send him to the ER. Nurse #7 stated she saw Resident #30 at the time of the transfer, but

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did not see any signs of injury. Nurse #7 could not recall if Resident #30's alarm sounded at the time he fell on 08/07/14, but recalled the fall interventions that were used for Resident #30 included a low bed, floor mats, and bed/chair alarms. Nurse #7 stated Resident #30 spent most of the time in bed on her shift or staff kept him at the nurse's station. Nurse #7 stated Resident #30 "fell all the time, at least once per week, he was always on the floor."

On 01/16/15 at 07:20 AM, NA #5 stated she did not work with Resident #30 that often, but remembered that as his health declined, he became very combative, confused, and had a high risk for falls. NA #5 stated that on the night of 08/07/14 she heard a resident across the hall from Resident #30 yelling that something was going on, but did not recall hearing an alarm sound. NA #5 arrived to Resident #30's room, found him seated on the side of his bed, without injury. Resident #82 stated he hit Resident #30 with his cane when the Resident got in bed with him and urinated. NA #5 stated she went and got the nurse.

An interview on 01/16/15 at 10:45 AM with NA #4 revealed she worked with Resident #30 on the 7 AM -3 PM shift and stated he frequently got up unassisted trying to go to the bathroom. She stated he was confused, required frequent orientation to his surroundings and frequent checks because he did not use his call light. NA #4 stated when she came on shift at 7 AM the morning of 08/07/14 and began her rounds, Resident #30 complained of pain to his head and arm and she saw a "golf ball sized" knot on the right side of his head and a bruise on his arm. NA #4 stated the nurse sent him out to the hospital.

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· On 08/12/14 at 10:20 AM, Resident #30 had an unwitnessed fall in his room and bumped his head. He was not injured. The post fall review documented that Resident #30 was wearing socks, had declining vision and had sustained increased falls as contributing factors to this fall. A recommendation for a sitter due to multiple falls and education to the Resident about the use of the call bell were documented as post fall interventions.

On 01/15/15 at 10:20 AM interview with the DON and review of the incident report dated 08/12/14 revealed Resident #30 was in his room unattended at the time of the fall. NA #6 entered the Resident's room and was informed by his roommate of the fall. The DON stated that the bed alarm should have been in place, but the incident report did not document whether or not it was in place and sounding. Resident #30 was referred to therapy and received occupational therapy from 08/13/14 - 09/11/14. The DON stated she could not recall the addition of a sitter as a post fall intervention. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident.

On 01/15/14 at 7:00 PM, nurse #4 stated she worked with Resident #30 on the 7 AM -3 PM shift. She stated Resident #30 was confused, required quick staff response to his alarm, at risk for falls due to his unsteady gait, poor vision and the staff assistance he required for transfers. Nurse #4 stated bed and wheel chair alarms were interventions used for Resident #30. Nurse #4 recalled that he fell while in his room unattended on 08/12/14, but was not injured. Nurse #4 stated

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staff always tried to make sure an alarm was in place for him, but she was not certain if it was in place and sounded at the time of this fall. Nurse #4 stated staff was alerted of the fall when a resident informed NA #6 that he had fallen. Nurse #4 stated she did not know what Resident #30 was doing at the time of the fall because she was providing patient care on the upper end of the hall. Nurse #4 stated Resident #30 fell a lot and at times the 2 nurse aides assigned could not get to him or other residents at high risk for falling, in time to keep them from falling if staff was providing patient care. Nurse #4 stated she provided injections to several residents on her shift and because of this it would take time to get to Resident #30 if he fell. Nurse #4 stated his bed was usually kept in low position, upper side rails raised, call bell in reach, but he didn't use it. Staff had to keep an eye on him and after he fell on 08/12/14 staff brought him into the hallway. Nurse #4 stated there were often 2 NA on the hall and this was difficult to monitor all the residents on the hall at high risk for falls. Nurse #4 stated an additional NA would have helped with monitoring residents. Nurse #4 stated staff did the best they could to watch the residents, but at times staff had to be in a resident's room providing care and not on the hall to monitor. Nurse #4 stated she communicated her concerns regarding staffing to management, but was told the staffing numbers were sufficient.

On 01/16/15 at 3:05 PM, NA #6 stated that on 08/12/14, the roommate of Resident #30 called out to her, when she entered the resident's room, she was informed that Resident #30 fell in his room and bumped his head. NA #6 stated she could not remember hearing an alarm sounding. Resident #30 was not injured and did not

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complain of pain. NA #6 informed his nurse he had fallen. NA #6 stated at the time of the fall, she was in another resident's room providing care, and Resident #30 was in his room unattended. NA #6 stated that staff tried to keep Resident #30 at the nurse's station, in an activity or tried to check on him every 30 minutes when he was in his room. NA #6 stated it was difficult to watch Resident #30 because at the time there were 3 other residents at risk for falls at the same time and all of the residents had alarms in place. NA #6 stated "we were constantly responding to alarms." NA #6 stated with just 2 NA "it was hard to get to all the alarms or to round on the residents and so we had a lot of falls." NA #6 stated staff spoke to the ADON about the lack of staff, but was told that we had to just work with the staff we had because the census was low.

· On 09/12/14 at 2:15 PM Resident #30 was found on the floor in his room lying on his side with his head on the floor. The fall was unwitnessed and he was uninjured. He complained of pain and was given Tylenol. The post fall review documented post fall interventions which included place Resident #30 at the nurse's station for close observation, staff to ensure the tabs alarm was on and functioning, floor mats at bedside and keep resident in close monitoring.

On 01/15/15 at 10:30 AM an interview with the DON and review of the incident report dated 09/12/14 revealed there was no documentation of whether or not an alarm was in place and functioning at the time of this fall. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident.

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On 01/15/14 at 7:00 PM, nurse #4 stated she worked with Resident #30 on the 7 AM - 3 PM shift. She stated Resident #30 was confused, required quick staff response to his alarm, at risk for falls due to his unsteady gait, poor vision and the staff assistance he required for transfers. Nurse #4 stated bed and wheel chair alarms were interventions used for Resident #30. Nurse #4 stated the fall that occurred on 09/12/14 occurred in his room while he was trying to get up to the bathroom. Nurse #4 stated a NA found him, but nurse #4 was not sure if the alarm was in place or sounded because she was not on the hall at the time, she was in a room charting.

On 01/16/15 at 3:10 PM NA #6 stated when Resident #30 fell on 09/12/14, she was in another resident's room providing care. She stated she heard an alarm sound, but when she got to Resident #30's room, she found him on the floor. She had previously laid him down for a nap about 1:00 PM and tried to round on him every 30 minutes, but stated " I probably didn't get to that day because there were only 2 of us on the hall." NA #6 stated staff tried to keep him at the nurse's station, in an activity, or checked on him every 30 minutes when he was in his room.

· On 09/30/14 at 09:15 AM, Resident #30 was observed seated on the floor beside his wheel chair. He sustained a hematoma to his head. The fall was unwitnessed. The post fall interventions included to get Resident #30 up to his wheel chair before breakfast.

On 01/15/15 at 10:39 AM, nurse #3 stated she was one of the routine nurses for Resident #30. Nurse #3 stated Resident #30 was confused and

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partially blind, had poor gait, and was monitored for fluctuating oxygen saturations, shortness of breath, agitation and unassisted attempts to get up from his wheel chair to use the bathroom. She stated he would not use his call bell despite staff reminders, so staff tried to keep the Resident visible. Resident #30 was at risk for falls so staff kept his bed positioned low, mats to the floor, alarms to bed/chair, and checked on him frequently. Nurse #3 stated when he fell on 09/30/14 it occurred right after breakfast, he was in his room in his wheel chair when his alarm sounded. Staff found him on the floor and nurse #3 assessed him with a hematoma to the back of his head and complaints of pain; neurological checks were initiated and he received pain medication as ordered.

On 01/15/15 at 11:17 AM NA #6 stated she worked with Resident #30 often and he was confused and at risk for falls. Staff tried to toilet him frequently, offered him snacks, encouraged activities, kept his bed low, and kept an alarm in place. NA #6 stated she did not remember the specifics of the fall on 09/30/14.

On 01/15/15 at 11:45 AM the DON stated that she did not have an incident report regarding a fall on 09/30/14. The DON was unaware of the interventions in place at the time of the fall. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident. Review of the care plan dated 08/18/14 documented post fall interventions included to get Resident #30 up to his wheel chair daily before breakfast.

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· On 10/02/14 at 6:50 PM, Resident #30 fell. There was no documentation regarding the time, location or outcome of this fall.

On 01/15/15 at 11:45 AM the DON stated she did not have an incident report regarding a fall on 10/02/14 and could not provide any additional information regarding this fall.

On 01/15/15 at 6:32 PM, nurse #9 stated she only worked with Resident #30 for about 1 month and did not remember much about him or the details of the fall that occurred on 10/02/14. Nurse #9 stated she remembered Resident #30 had an alarm in place because of his fall risk and was often kept at the nurse's station or in the dining room for monitoring.

On 01/15/15 at 6:40 PM NA #7 stated she worked with Resident #30 routinely on the 3 PM - 11 PM shift from September - November 2014. NA #7 stated Resident #30 fell a lot, but she did not remember a specific fall that occurred. She stated he was confused, constantly got up unassisted and had poor eyesight. NA #7 stated Resident #30 had a tab alarm and bed alarm, bed positioned low, and staff tried to toilet him often. NA #7 stated that sometimes if a staff member called out, this left only 1 NA on the hall; there was no one to stay and help. NA #7 stated Resident #30 spent time in his room, "that's where he stayed the majority of the time and we would be able to see him in the room when we walked by."

· On 10/22/14 at 3:30 PM, Resident #30 was found seated on the floor in his bathroom with the oxygen tubing wrapped around his ankles. The fall was unwitnessed. Resident #30 complained

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of pain to his right elbow and right hip, he was medicated per physician's order. An Xray was ordered of his right hip and right elbow; the results dated 10/22/14 recorded "suspicious for a non-displaced fracture of the right illium (pelvis bone)." The post fall intervention included to place Resident #30 on a toileting program.

On 01/15/15 at 11:45 AM the DON stated during review of the incident report dated 10/22/14 Resident #30 took went to the bathroom independently and that there was no documented indication that and an alarm sounded to alert staff. The DON stated she was not sure of the type of alarm Resident #30 had in place as an intervention at the time of the fall that occurred on 10/22/14. She further stated that the committee was trying to do a better job at looking for documentation of the interventions that were in place at the time of an incident. The DON stated the NA assigned was no longer an employee; attempts to reach this NA were unsuccessful. The DON stated that the post fall intervention for the 10/22/14 fall documented that Resident #30 was placed on a toileting program.

On 01/15/15 3:30 PM, NA #4 stated she remembered hearing an alarm sound when Resident #30 fell on 10/22/14, by the time staff arrived he was on the bathroom floor with the oxygen tubing wrapped around his legs. NA #4 stated Resident #30 was in the bed prior to the fall and he got up to go to bathroom.

On 01/16/15 at 09:11 AM the DON stated during a follow up interview that Resident #30 was not placed on a toileting program because the facility did not use this approach, but rather Resident #30 should have been placed on a prompted

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toileting program in which staff would have assisted Resident #30 with toileting upon rising, before meals and at bedtime. She stated the toileting program was documented in error.

On 01/16/15 at 12:51 PM nurse #10 stated that Resident #30 was alert confused, made frequent attempts to use bathroom without staff assistance. When Resident #30 fell on 10/22/14, nurse #10 stated an alarm sounded and staff responded. Prior to the fall, nurse #10 stated Resident #30 was in bed sleeping. Resident #30 was found on the bathroom floor with oxygen tubing wrapped around his ankles, he complained of pain and he was medicated per physician's order. An Xray was obtained per physician's order and showed a possible pelvis bone fracture. Nurse #10 stated staff had to pay special attention to Resident #30 because of his frequent attempts to get up unassisted.

· On 10/26/14 at 4:15 PM, Resident #30 was found in the resident's lounge lying on his right side. He was uninjured and the fall was unwitnessed. The post fall intervention was to keep Resident #30 in a visible area.

On 01/15/15 at 11:45 AM the DON stated the incident report dated 10/26/14 did not document if an alarm sounded at the time of the fall. She stated that the post fall intervention was to keep Resident #30 visible to staff. The DON stated the NA assigned to Resident #30 at the time of the fall was no longer employed. Attempts to reach the NA were unsuccessful.

On 01/15/15 at 6:00 PM nurse #2 stated she was the nurse assigned when Resident #30 fell on 10/26/14. Nurse described Resident #30 as alert,

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confused and at high risk for falls and fell frequently. Nurse #2 stated staff used a wheel chair and bed alarm to alert staff if he made attempts to get up unassisted. Nurse #2 stated staff rounded on Resident #30 at least every hour to make sure he was not trying to get up unassisted. Nurse #2 stated when Resident #30 fell on 10/26/14 in the resident's lounge, he was unattended and an alarm sounded, the NA found him on the floor and came to advise her of the fall. Nurse #2 stated she assessed Resident #30 without injury and due to continued attempts to get up unassisted she kept Resident #30 with her as she completed her medication pass. Nurse #2 stated she was not aware that Resident t#30 was left in the resident's lounge unattended, but stated had the NA told her he was left alone, nurse #2 would have recommended that Resident #30 be placed somewhere staff could watch him, because she stated "if you don't watch him he will try to get up unassisted."

On 01/16/15 at 4:17 PM, the ADON stated that a committee met each morning Monday - Friday after a resident fell to determine the possible cause of the fall. The ADON stated referrals were made for the resident as needed, and the care plan and NA care sheets were was updated with any new interventions. The ADON stated that some staff expressed concerns to her related to insufficient staffing and asked for more help, but she tried to help them understand that the staffing pattern was sufficient. The ADON stated she believed there was adequate supervision for Resident #30 and stated "we did the best we could." The ADON stated that if the interdisciplinary team felt one to one supervision was needed for Resident #30, it would have been provided, but the interdisciplinary team didn't feel

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it was necessary. The ADON stated in a follow up interview on 1/16/15 at 7:00 PM that the quality assurance (QA) committee identified frequent resident falls as problem in October 2014 and began to identify fall trends. She stated that a reduction in the number of resident falls occurred between October 2014 - December 2014 (October - 19 falls, November -14 falls, and December - 6 falls). On 11/20/14 nursing staff were in-serviced and re-education to monitor residents, assist with toileting, take residents to the dining room for breakfast, and encourage residents to attend activities to help reduce the number of resident falls. The ADON stated that when the January 2015 QA meeting occurred the team would review and discuss the monitoring for effectiveness.

3. Resident # 83 was admitted to the facility on 02/24/14 with diagnoses which included cerebral vascular accident and congestive heart failure.

Review of Resident # 83's Minimum Data Set (MDS) dated 10/26/14 revealed an assessment of severely impaired cognition. Resident #83 required the extensive assistance of one person with dressing.

Review of Resident #83's care plan dated 10/31/14 revealed a requirement for assistance in activities of daily living and a potential for pressure sore development. Interventions included application of geriatric sleeves or a long sleeved shirt for both arms.

Review of monthly physician's orders dated 01/05/15 revealed direction to apply geriatric sleeves to Resident #83's bilateral arms with

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removal every shift for skin inspection.

Review of Resident #83's resident care specialist assignment sheet revealed Resident #83 was to wear geriatric sleeves or long sleeves when out of bed.

Observation on 01/12/15 at 12:14 PM revealed Resident #83 seated in a wheelchair wearing a short sleeved shirt and no geriatric sleeves. Resident #83 was unwrapping a bandage above the left wrist. An approximately 1.5 centimeter (cm.) diameter bruise was above the approximately 0.5 cm. skin tear on the left wrist. An approximately 1.5 cm. by 2.0 cm. bruise was on Resident #83's lateral left arm above the elbow. Resident #83 moved both arms voluntarily.

Observation on 01/13/15 at 8:41 AM revealed Resident #83 seated in a wheel chair. Resident #83 wore a short sleeved shirt and did not wear geriatric sleeves. Resident #83's bruises remained unchanged.

Observation on 01/13/15 at 1:05 PM revealed Resident #83 seated in a wheel chair. Resident #83 wore a short sleeved shirt and did not wear geriatric sleeves. Resident #83's bruises remained unchanged.

Observation on 01/14/15 at 8:25 AM revealed Resident #83 seated in a wheel chair. Resident #83 wore a short sleeved shirt and did not wear geriatric sleeves. Resident #83's bruises remained unchanged.

Interview with Nurse Aide (NA) #1 on 01/14/15 at 9:16 AM revealed Resident #83 should wear

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F 323	Continued From page 45 geriatric sleeves. NA #1 explained Resident #83 did not own long sleeved shirts and there were no geriatric sleeves in the room. NA #1 reported she would obtain geriatric sleeves from the supply room. NA #1 could not provide a reason for the absence of geriatric sleeves but explained Resident #83 bruised easily and should wear them at all times. Interview with Nurse #2 on 01/14/15 at 9:29 AM revealed Resident #83 should wear geriatric sleeves at all times. Nurse #2 explained nurse aides applied the geriatric sleeves and she did not notice the absence of the geriatric sleeves. Interview with the Director of Nursing on 01/14/15 at 10:35 AM revealed she expected staff to follow the resident care specialist assignment sheet and Resident #83 should wear geriatric sleeves on both arms.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of a policy, the facility failed to sanitize a	F 371	Part 1: Criteria 1:	2/20/15

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F 371	Continued From page 46 dial thermometer in between use. The thermometer was used to obtain a temperature of 100 degrees Fahrenheit for a potentially hazardous food and used again to check the temperature of a food item without being sanitized. Additionally, the facility failed to label and date thawing ground beef stored in refrigeration. The findings included: A facility policy, Food Preparation, dated May 2014, recorded in part, "The Food Services Director or Cook(s) is responsible to ensure that all utensils, food contact equipment, and food contact surfaces are cleaned and sanitized after every use." 1. An observation of the lunch meal tray line occurred on 01/16/15 from 11:55 AM - 12:30 PM. At 11:59 AM, dietary staff #1 was observed to remove a long 6 inch stainless steel pan of fried chicken from the oven and placed it on the steam table. He conducted temperature monitoring of a piece of fried chicken (thigh) using the facility's dial thermometer. He stated the thermometer was previously checked for calibration earlier that day. The fried chicken was observed with a temperature of 100 degrees Fahrenheit (F). He placed the dial thermometer on top of the box lid of individually wrapped alcohol wipes. He placed the first pan of fried chicken back in the oven and removed a second pan of fried chicken from the oven and placed it in a well on the steam table. Dietary staff #1 was observed to use the same dial thermometer to check the temperature of a piece of fried chicken (thigh) from the second pan of fried chicken without sanitizing the thermometer prior to use. Dietary staff #1 then	F 371	Trays 1 and 2 were discarded by dietary aide on 1/16/2015 following an inappropriate temperature evaluation. Criteria 2: Dietary Manager re-educated dining team on proper sanitation procedure when assessing food temperatures using a thermometer on 1/19/2015. Criteria 3: Dietary Manager will monitor proper sanitation procedures when checking food temperatures using a thermometer 3x week for 12 weeks. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved. Part 2: Criteria 1: Meat that was identified to not have a use by date but did contain a thaw date of	

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F 371	Continued From page 47 stated he was ready to start the lunch tray line and began plating residents' meals for lunch. During an interview with dietary staff #1 on 01/12/15 at 12:05 PM he confirmed that he obtained a temperature of 100 degrees F for the fried chicken when he used the thermometer and that he was trained to sanitize the thermometer in between use. Dietary staff #1 further stated "Yeah, I probably didn't" when he was asked if he realized that he did not sanitize the dial thermometer in between use. The CDM was informed by the surveyor on 01/12/15 at 12:18 PM of the observation of the dial thermometer that was not sanitized in between use. The CDM was observed to instruct dietary staff #1 not to serve the fried chicken on the steam table and to recheck the temperature of the first pan of fried chicken that was stored in the oven. The CDM stated that the dial thermometer should have been sanitized in between use since the thermometer was placed on top of the box lid of the alcohol wipes and because a temperature of 100 degrees, which is in the danger zone (42 - 134 degrees F) was obtained for the fried chicken. 2. An observation occurred on 01/12/15 at 10:08 AM of the walk-in refrigerator. Two packages of ground beef (one unopened with 10 pounds and one opened with approximately 8 pounds) was observed stored on the bottom shelf of the walk-in refrigerator in a cardboard box. The date "01/06/14" was recorded by the facility on the exterior of box. The package with approximately 8 pounds of ground beef had a facility label with the date "01/08/14" recorded. The package of 10 pounds of ground beef did not have a label or	F 371	1/8/2015 was used on 1/12/2015 within the 7 days required by policy. time frame set forth by the company. All other meat items were reviewed for proper labeling and were found to be in compliance. Criteria 2: On 1/192015, the Dietary Manager re-educated dining team regarding the policy on labeling and dating stored foo items, to include acceptable label for Date Thawed and Use By date. Criteria 3: Dietary Manager will monitor meat labeling for proper use of THAW and USE BY labels 3x a week times 12 weeks. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 48 date to indicate when it was stored in refrigeration to thaw. Interview with the CDM at the time of the observation revealed that the date of "01/06/14" recorded by facility staff on the exterior of the cardboard box was the date of receipt. The CDM further stated that the ground beef was received frozen, but she was not sure when the 10 pound package of ground beef was placed in refrigeration to thaw. The CDM stated the ground beef was on the menu for the lunch meal that day (01/12/15). An interview with dietary staff #1 occurred on 01/12/15 at 10:10 AM revealed he saw the box of ground beef in the walk-in, but did not know when the 10 pound package of ground beef was placed in refrigeration to thaw. An interview with the regional CDM occurred on 01/12/15 at 11:16 AM and revealed that both packages of ground beef was received on 01/16/15 and placed in refrigeration on 01/08/15 to thaw. She confirmed that the 10 pound package of ground beef should have been labeled with the date it was placed in refrigeration to thaw. A follow-up interview with the CDM occurred on 01/16/15 at 4:16 PM. The interview revealed that the ground beef should have been labeled with the date placed in refrigerator to thaw.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		2/20/15

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F 441	Continued From page 49 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff, nurse practitioner and physician interview, and record review, the facility failed to disinfect a glucose meter (used for blood sugar monitoring) after a finger stick	F 441	Part 1: Criteria 1: On 1/14/2015 glucometer was disinfected for a second time with the 1 min contact	

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F 441	Continued From page 50 blood sugar for 2 of 2 sampled residents observed for finger stick blood sugar checks (Residents #5 and #45) and failed to implement contact precautions for 1 of 2 sampled residents who required contact precautions (Resident #103). The findings included: 1. Review of the label on the bleach wipe container in the 300 hall medication cart revealed direction for blood borne pathogen disinfection. The directions specified to use enough wipes to remain visibly wet for the contact time listed. The contact time listed one minute for blood borne pathogens. Review of the facility's undated procedure titled: "Cleaning and Disinfecting Glucometers" listed directions to wipe thoroughly wetting the exterior of the equipment surface with the bleach wipe. The direction included use of "additional wipes if necessary to ensure glucose meter visibly wet." The procedure did not specify a time to remain visibly wet when routinely performed. The procedure indicated the glucose meter should be wiped and wrapped in a wipe for 3 minutes when used on residents with Clostridium difficile infection and have a contact time of 1 minute for residents with hepatitis. Interview with Nurse #1 on 01/14/15 at 8:01 AM revealed residents shared a glucose meter which staff disinfected after each use. Observation on 01/14/15 at 11:23 AM revealed Nurse #1 obtained Resident #45's finger stick blood sugar with a glucose meter. Nurse #1 removed a wipe out of the bleach wipe container	F 441	time. A second glucometer was used while this was being done. One on one education and return demonstration was completed with Nurse #1 and #2 on 1/14/2015. Criteria 2: The Director of Nursing will update the current practice of glucometer cleaning to reflect the manufacturers instructions. The Director of Nursing or Staff Development Nurse will re educate will be initiated to all licensed nurses on the disinfection of glucometers. All nurses will complete a return demonstration of glucometer disinfection by 2/20/15. Criteria 3: The Director of Nursing or Staff Development Nurse will conduct glucometer cleaning audits 4 times a week for 2 weeks. Two times a week times 4 weeks, then weekly times two months. Any opportunities identified will be corrected. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance	

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F 441	Continued From page 51 and wiped the meter on all four sides. Nurse #1 placed the glucose meter on the wipe on top of the medication cart. The top and sides of the glucose meter were not visibly wet. Interview with Nurse #1 on 01/14/15 at 11:33 AM revealed the blood glucose monitor did not require visible wetness. Nurse #1 explained she wiped all areas and left it open to air to dry which was her usual practice. Interview with the Director of Nursing (DON) on 01/14/15 at 11:46 AM revealed the glucose meter should remain visibly wet for one minute. A second interview with the DON on 01/14/15 at 12:26 PM revealed she thought a 30 second period of visible wetness would be sufficient since the product also specified blood and bodily fluids be thoroughly cleaned from the surface for a 30 second interval prior to wipe application to disinfect. 2. Review of the label on the bleach wipe container in the 200 hall medication cart revealed direction for blood borne pathogen disinfection. The directions specified to use enough wipes to remain visibly wet for the contact time listed. The contact time listed one minute for blood borne pathogens. Review of the facility's undated procedure titled: "Cleaning and Disinfecting Glucometers" listed directions to wipe thoroughly wetting the exterior of the equipment surface with the bleach wipe. The direction included use of "additional wipes if necessary to ensure glucose meter visibly wet." The procedure did not specify a time to remain visibly wet when routinely performed. The	F 441	and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved. Part 2: Criteria 1: Resident #103 discharged from facility on 11/24/2014. Criteria 2: The Director of Nursing conducted an audit of all residents potentially affected was completed on 2/6/2015. At the time, the building had one resident that was on isolation and the facility was following the CDC guidelines for isolation precaution for that resident. Criteria 3: The Director of Nursing or Staff Development Nurse will re-educate Resident Care Specialist and Licensed Nurses on isolation precaution by 2/20/2015. Director of Nursing or Assistant Director of Nursing will randomly audit residents for isolation and review with Medical Director weekly for 12 weeks. Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any	

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F 441	Continued From page 52 procedure indicated the glucose meter should be wiped and wrapped in a wipe for 3 minutes when used on residents with Clostridium difficile infection and have a contact time of 1 minute for residents with hepatitis. Observation on 01/14/15 at 11:55 AM revealed Nurse #2 obtained Resident #5's finger stick blood sugar with a glucose meter. Nurse #2 removed a wipe from the bleach wipe container and wiped the meter on all four sides. Nurse #2 placed the glucose meter on the wipe on top of the medication cart. The top and sides of the glucose meter were dry in 28 seconds. Interview with Nurse #2 on 01/14/15 at 12:04 PM revealed the facility used wipes with a 5 minute requirement in the past but the wipes used today did not have a requirement for visible wetness. Interview with the Director of Nursing (DON) on 01/14/15 at 11:46 AM revealed the glucose meter should remain visibly wet for one minute. A second interview with the DON on 01/14/15 at 12:26 PM revealed she thought a 30 second period of visible wetness would be sufficient since the product also specified blood and bodily fluids be thoroughly cleaned from the surface for a 30 second interval prior to wipe application to disinfect. 3. Review of a facility policy titled Type and Duration of Precautions Needed for Selected Infections and Conditions dated 2012 referenced the 2007 Center for Disease Control and Prevention (CDC) guidelines isolation precautions. For herpes zoster (shingles) infection with "localized disease in immunocompromised patient until disseminated	F 441	items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	

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F 441	Continued From page 53	F 441		

infection ruled out," contact isolation was noted as a precaution for the duration of the illness.

A review of facility infection control surveillance reports revealed an August 2014 entry of Resident #103 with a diagnosis of shingle (herpes zoster). Further review of Resident #103's closed record revealed a nurse communication form to the provider dated 08/03/14 by Nurse # 4 who documented the presence of red bumps on the resident's bilateral thighs. The resident was reported as denying any pain, itching or discomfort and as not recalling what may have caused the condition. Review of a nurse practitioner (NP) note dated 08/04/14 revealed the presence of a pustular rash to the resident's right lower extremity and a few areas to her left lower extremity. The NP noted the resident was in hospice care and had shingles in the past. The NP examination noted few pustules on a red base on the resident's right lower extremity. The NP assessed the rash as shingles with a question mark preceding the diagnosis. Review of a NP order dated 08/04/14 revealed Resident #103 was prescribed the antiviral medication acyclovir 5% cream, to be applied to the lower extremity rash 5 times daily for 7 days for shingles. A review of provider orders did not reveal an order for contact isolation precautions.

An interview with Nurse #1 on 01/15/15 at 1:17 PM revealed staff had access to carts with equipment and supplies used for contact isolation. She stated for residents with herpes zoster they could have drainage so gowns would be worn. She stated gloves and gowns would be worn by staff.

A phone interview with Nurse # 4 on 01/15/15 at

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F 441	Continued From page 54	F 441		

7:44 PM revealed if residents had herpes zoster they should be placed in contact isolation. She stated she recalled Resident #103 and she did know of her shingles status. She stated she wore double gloves occasionally and thought she wore gowns occasionally but not all the time. She stated she did not recall a cart with supplies outside the resident's door nor did she recall a sign posted on the resident's door for contact precautions.

A phone interview on 01/16/15 at 12:37 PM with the NP revealed that contact precautions were taken into consideration for residents with shingles. She stated nurses were knowledgeable about precautions and the various levels of precaution. She stated the resident was immunocompromised and treated for shingles, having no open scabs or weeping but having intact pustules. She stated she could not recall the resident being placed in contact isolation or having a discussion with nursing staff regarding any need to place the resident in isolation.

A phone interview on 01/16/15 at 4:11 PM with the attending physician revealed he recalled Resident #103 but could not remember the particulars of her clinical presentation. He stated nurses inquired about isolation precautions for residents with possible communicable diseases. He stated that for residents with shingles there should be a discussion with regard to the level of precaution. He stated it would be good for staff to review CDC guidelines with regard to shingles for awareness of the proper level of precaution. He stated herpes zoster titers were not indicated as treatment could be initiated based on the clinical presentation of the resident.

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F 441	Continued From page 55 An interview on 01/16/2015 at 5:30 PM with the assistant director of nursing (DON) and the DON revealed that a resident with shingles should be evaluated to determine if isolation precautions were indicated. They stated staff should refer to the CDC guidelines in the facility policy for this information. They stated nurses and providers discussed these issues and felt that the illness would not spread if the resident did not leave the room and staff were good to use gloves.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		2/20/15

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F 520	Continued From page 56 This REQUIREMENT is not met as evidenced by: The facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2013. This was for one recited deficiency which was originally cited in September of 2013 on a recertification survey and subsequently recited in January of 2015 on the current recertification survey. The deficiency was in the area of dietary services. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 371 Dietary Services: Based on observations, staff interviews and review of a policy, the facility failed to sanitize a dial thermometer in between use. The thermometer was used to obtain a temperature of 100 degrees Fahrenheit for a potentially hazardous food and used again to check the temperature of a food item without being sanitized. Additionally, the facility failed to label and date thawing ground beef stored in refrigeration. The facility was recited for F371 for failing to sanitize a thermometer and properly label, date and store items in refrigeration. F371 was originally cited during the September 13, 2013 recertification survey for failing to label, date, and store food items brought in by a family member, maintain a clean ceiling in the kitchen, and maintain paint on metal kitchen doors to prevent	F 520	Criteria 1: Kitchen began auditing for food labeling and kitchen cleanliness on 12/31/2014 when new Dietary Manager began. Daily audits have been maintained and given to the state survey team for review to note that the Quality Assurance Committee was still monitoring the process. Criteria 2: Administrator and DON will implement a Quality Assurance Tracking Tool that will be maintained for any active Quality Assurance Performance Improvement Plans to ensure compliance is being maintained. Quality Assurance and Performance Improvement Committee decided to adopt this process during the monthly Quality Assurance and Performance Improvement meeting on 2-4-2015. Criteria 3: The newly implemented Quality Assurance Tracking Tool will accompany all audits being submitted to the Quality Assurance and Performance Improvement Committee at each monthly meeting. Administrator and DON will monitor for compliance of submission. 2/20/2015 Criteria 4: The Quality Assurance and Performance Improvement Committee will review the audit results and follow up on any action	

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F 520	Continued From page 57 rust. An interview conducted with the Administrator on 01/16/15 at 5:55 PM revealed that during the facility's previous recertification survey completed 09/13/13 the facility was cited for failing to properly label, date and store items in the refrigeration. The administrator stated in response to the citation the facility developed a Plan of Correction that directed her to complete rounds weekly. The administrator explained that these weekly audits were not completed by staff as planned and no follow up was performed by facility's QAPI committee. She further stated the previous dietary manager did not complete the weekly monitoring as expected. The new dietary manager has continued with ongoing monitoring. She further stated that weekly monitoring for a few months were missed.	F 520	plans during the monthly Quality Assurance and Performance Improvement Committee meeting. Any items on the action plan will be completed to ensure continued compliance. The Quality Assurance and Performance Improvement Committee will determine if any further education is needed based on results of audits. The Quality Assurance and Performance Improvement Committee has the right to discontinue the audits once the committee determines compliance has been achieved.	