STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345396	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY MOUNTAIN HEALTH AND REHABILITATION CENTER	1349 CRABTREE ROAD WAYNESVILLE, NC 28785

(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 No deficiencies were cited as a result of the complaint investigation Event ID # 2FXY11.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		9/16/15

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

Electronically Signed | 09/11/2015

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interviews the facility failed to notify the resident's physician of a change in condition related to syncopal episodes for 1 of 2 sampled residents (Resident #44). The findings included: Resident #44 was admitted on 06/29/15 with diagnoses that included heart failure, hip replacement, dislocated shoulder, diabetes, and orthostatic hypotension - which involves a blood pressure drop when moved from a lying or sitting position to a standing position. The 30 day Minimum Data Set dated 07/27/15 indicated Resident #44 was cognitively intact and required extensive assistance with 1 to 2 persons for most activities of daily living including transfers, locomotion on and off the unit, and personal hygiene. Resident #44 had impairment on one side of her upper extremities and shortness of breath with exertion. Resident #44 was noted to be at risk for pressure ulcer development, and had fragile skin. She was to receive special care to avoid skin tears. Resident #44's care plan dated 07/22/15 revealed she was a fall risk and had a potential for skin tears due to fragile skin. She was transferred from a sitting position with the aid of a Sabina lift, which was a lift that required Resident #44 to be transferred from a sitting to a standing position. On 08/25/15 the care plan was updated for her to be transferred with a Viking lift, which transferred Resident #44 in a sitting position.	F 157	Smoky Mountain Health and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and 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. Smoky Mountain Health and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Smoky Mountain Health and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F157: On 8/25/15, the director of nursing (DON) changed Resident #44¿s transfer method from a Sabina lift to a Viking lift due to syncope events and to help prevent skin tears. Nurse # 2 was re-trained and issued a disciplinary action due to not notifying the physician or on-call physician of a change in condition concerning resident #44. On 8/25/15, the MDS nurse updated Resident #44¿s resident care	

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F 157	Continued From page 2 The nurse's notes dated 08/19/15 indicated Resident #44 "passed out" when being transferred from the toilet back to her bed with the aid of the Sabina lift. The nurse's notes dated 08/23/15 revealed staff was called to Resident #44's room by a family member who stated Resident #44 had "passed out" while sitting up in a chair. There was no indication of physician notification of the 08/23/15 incident. A skin referral form dated 08/23/15 revealed Resident #44 had a new skin tear to her left shin. Review of the flowsheet for non-ulcer skin conditions dated 08/24/15 indicated Resident #44 had a 3 centimeter (cm.) skin tear to the left lower leg that was due to a syncopal (passing out) episode while in the Sabina lift. Resident #44 had a 4cm. x 5cm. hematoma to her left shin after a syncopal episode in the Sabina lift. Nurse's notes dated 8/25/15 and an incident report of the same date acknowledged Resident #44 had a syncopal episode when she was placed in a Sabina lift in an upright position and sustained a skin tear to her right lower leg. Non-ulcer skin condition flow sheets dated 08/25/15 indicated Resident #44 had a 4 cm. skin tear to her right shin after a syncopal episode in the Sabina lift and an L-shaped purple, hematoma above the skin tear. Non-ulcer skin condition sheets dated 08/27/15 indicated Resident #44 had 3 small skin tears to right lower leg. It also revealed she had a purple hematoma on the right lower leg and the 3 skin tears had opened up over the hematoma. On 08/24/15 at 10:32 AM an interview was conducted with Resident #44 after observations	F 157	plan and resident care guide to reflect the new changes. On 8/28/15, the DON in-serviced 100% of RNs and LPNs on the importance of notifying the appropriate physician, the Health Care Power of Attorneys (HCPOA) or responsible party (RP), and the facility on-call nurse when the resident has a change in condition and to document the responses in a progress note. On 9/1/15, the assistant director of nursing (ADON) in-serviced 100% of nursing assistants to notify their assigned nurse when a resident has a change in condition. Using a Change in Condition auditing tool developed by the DON, the DON and/or ADON will monitor 100% of nursing progress notes for a look back period of 24 hours to identify resident change in condition. The Change in Condition auditing tool will be completed 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then 1 day a week x 4 weeks. Any concerns noted by the DON and/or ADON will be addressed immediately by the DON and/or ADON. The ADON and/or DON will report the audit results at the weekly meeting of the QI committee (administrator, DON, ADON/QI, MDS nurses, treatment Nurse, and dietary manager). The ADON/QI nurse will also report the audit results and corrective actions taken to the monthly and quarterly Executive QA Committee	

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F 157	Continued From page 3 of bandages and bruises were made of her lower extremities. She indicated she had passed out in the Sabina lift. Resident #44 indicated this had been occurring for several days. On 08/26/15 at 10:50 AM an interview was conducted with Resident #44. She indicated she had "several" incidences when she was gotten up in an upright position in the Sabina lift to help her with a transfer, and she would pass out. She indicated the syncopal episodes had begun the prior week, but she was not sure of the day. Resident #44 stated when she had the syncopal episodes in the Sabina lift, she would slide down in the lift and that caused her skin tears. She acknowledged her skin was very easy to bruise and tear. On 08/26/15 at 2:50 PM an interview was conducted with Nurse Aide #1 (NA#1). She stated she had taken care of Resident #44 since she came to the facility a couple of months earlier. She stated the NAs had been getting Resident #44 up in a Sabina lift, and she started having syncopal episodes. NA#1 indicated she wasn't sure when her first syncopal episode was, but she believed it was the prior week. She stated when Resident #44 was gotten up in the Sabina lift, she would black out until she was lowered back to a seated position. NA#1 acknowledged Resident #44 had several syncopal episodes on 08/24/15. She stated the first time it occurred Resident #44 was lowered back into her chair and she regained consciousness. She stated her vital signs were checked and her blood pressure was in the 90 over 50 range. NA#1 stated Nurse #2 was in the room at the time. NA#1 revealed she informed Nurse #2 that Resident #44 had blacked out again when gotten up in the Sabina	F 157	(Medical director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager). Any recommended changes will be discussed and carried out as agreed upon.	

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F 157	Continued From page 4	F 157		

lift the second time it occurred on 08/24/15.

On 08/26/15 at 3:50 PM an interview was conducted with Nurse #2. She stated she was in Resident #44's room on 08/24/15 the first time she passed out. She indicated Resident #44 was gotten up in the Sabina lift and had a syncopal episode and was returned to her chair. Nurse #2 indicated she was not aware if Resident #44 sustained any injuries or skin tears from this episode. She stated the second time Resident #44 had a syncopal episode on 08/24/15, she was called into the room by the nurse aides and she checked her vital signs. She stated she had a low blood pressure, but she didn't think that was anything different for Resident #44. Nurse #2 indicated she made the comment she thought the lift could be causing Resident #44's syncopal episodes, but she wasn't sure to whom she had commented. She stated she did not call the doctor on either occasion because she did not think this was a different situation for Resident #44.

On 08/26/15 at 4:55 PM an interview was conducted with Nurse #1, who was the treatment nurse. She stated Resident #44's two skin tears on her left shin occurred on 08/24/15 during the syncopal episode in the Sabina Lift.

On 08/27/15 at 10:40 AM an interview was conducted with Assistant Director of Nursing (ADON). She indicated she was aware Resident #44 had been having syncopal episodes when gotten up in the Sabina lift. The ADON indicated she was not aware the physician had not been notified of the lift incidents on 08/23/15 and 08/24/15. She stated it was her expectation that Resident #44's Power of Attorney and physician

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F 157	Continued From page 5 would be notified by the nursing staff for any change that occurred to the resident. The ADON stated that each time Resident #44 had a syncopal episode, the physician should have been notified. On 08/27/15 at 1:45 PM an interview was conducted with the facility medical director. He indicated he was aware of the syncopal episode that occurred on 08/19/15 because he was in the facility at that time. He stated he was not made aware of syncopal episodes that occurred on 08/23/15 and 08/24/15.The medical director revealed it was his expectation the staff would have notified him when the syncopal episodes occurred. On 08/27/15 an interview was conducted with the Director of Nursing. She stated she was informed of the 08/24/15 syncopal episodes of Resident #44 on 08/25/15, and she changed the lift from a Sabina lift to a Viking lift. She stated it was her expectation that the staff notified the physician as well as herself for any type of change in condition.	F 157		
F 272 SS=D	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;	F 272		9/16/15

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F 272	Continued From page 6 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; 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 observations, record review and staff interview the facility failed to accurately assess the dental status of 1 of 17 residents whose assessments were reviewed. (Resident #11). The findings included: Resident #11 was admitted to the facility on 09/02/14 with diagnoses including diabetes mellitus, coronary artery disease and	F 272	F272: On 8/26/15, the MDS nurse updated Resident #11¿s care plan to reflect correct dental assessment. On 8/27/15, the MDS nurse updated Resident #11¿s care guide. On 8/26/15, the Social Services Director discussed with Resident #11 the use of	

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F 272	Continued From page 7 hypertension. An admission Minimum Data Set (MDS) assessment dated 09/02/14 indicated Resident #11 had no cognitive impairment. The MDS section L0200B "No natural teeth or tooth fragments (edentulous)" was answered "no." The Care Area Assessment summary for nutrition indicated resident ate majority of meals and was not on a therapeutic diet because she chose not to follow it. Observation of Resident #11 on 08/25/15 at 11:13 AM revealed she had no teeth. Interview with Resident #11 revealed she had dentures at home but did not use them because she thought they "looked like mule teeth." Resident denied having difficulty eating. An interview on 08/26/15 at 3:11 PM with the MDS assessment nurse about the process for assessing a resident's dental needs revealed she talked to the resident with every MDS that she completed and checked the resident's mouth if the resident would allow her to do so. When asked if she had checked Resident #11, the MDS nurse stated the resident did not have any teeth and didn't wear her dentures. The MDS nurse stated the resident had been asked if she wanted to see a dentist and she had refused. The MDS nurse was asked about the inaccurate coding on the Admission MDS and she stated the Director of Nursing (DON) had completed the Admission MDS. An interview on 08/26/15 at 3:24 PM with the DON revealed the Admission MDS was completed by another nurse, who was no longer employed at the facility. The DON stated she had signed the Admission MDS to indicate that it was completed. The DON stated she thought she had	F 272	dentures and documented the discussion. Resident #11 stated not interested in dentures at this time but would notify staff if interested at a later time. On 9/5/15, the DON in-serviced 100% of RNs and LPNs to assess a resident¿s dental, hearing, and vision status upon admission and to document the assessment in nursing progress notes and on the resident care guide. On 9/10/15, the MDS nurses and ADON reviewed and corrected 100% of residents care guides and care plans concerning dental status to include dentures, natural teeth, or edentulous. Beginning 9/14/15, RNs, LPNs, and/or the social services director are to note on the resident care guide denture/teeth status upon resident admission. Also upon a resident admission, the social services director will discuss with resident/family the need or desire for dentures. The social services director will document the resident/family discussion and preference in a social progress note. MDS nurses will address dental status upon MDS assessments for all residents and place on resident care plans. The DON and /or ADON will audit RN and LPN nursing admission progress notes and new resident care guides for documentation of denture/teeth status within 2 days of admission. The monitoring will be documented on the Admission audit tool within 2 days of a	

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F 272	Continued From page 8 seen Resident #11 wearing dentures in the past but couldn't be sure. A second interview with the DON on 08/26/15 at 5:58 PM revealed the DON recalled previously providing care for Resident #11 in another health care facility. The DON stated she had never seen Resident #11 wearing dentures while at the facility. The DON had no explanation for the inaccurate coding of the Admission MDS. .	F 272	resident¿s admission for a period of 3 months. Any discrepancies or omissions of dental status will be immediately addressed and corrected by the DON and/or ADON. The ADON and/or DON will report the audit results at the weekly meeting of the QI committee (administrator, DON, ADON/QI, MDS nurses, treatment Nurse, and dietary manager). The ADON/QI nurse will also report the audit results and corrective actions taken to the monthly and quarterly Executive QA Committee (Medical director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager). Any recommended changes will be discussed and carried out as agreed upon.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record reviews the facility failed to implement alternative transfer equipment or techniques to transfer 2 of 2 sampled residents which led to skin tears on Resident #44 and falls	F 323	F323: On 8/25/15, the director of nursing (DON) changed Resident #44¿s transfer method from a Sabina lift to a Viking lift due to	9/16/15

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F 323	Continued From page 9 on Resident #45. The findings included: 1. Resident #44 was admitted on 06/29/15 with diagnoses that included heart failure, hip replacement, dislocated shoulder, diabetes, and orthostatic hypotension - which involves a blood pressure drop when moved from a lying or sitting position to a standing position. The 30 day Minimum Data Set dated 07/27/15 indicated Resident #44 was cognitively intact and required extensive assistance with 1 to 2 persons for most activities of daily living including transfers, locomotion on and off the unit, and personal hygiene. Resident #44 had impairment on one side of her upper extremities and shortness of breath with exertion. Resident #44 was noted to be at risk for pressure ulcer development, and had fragile skin. She was to receive special care to avoid skin tears. Resident #44's care plan dated 07/22/15 revealed she was a fall risk and had a potential for skin tears due to fragile skin. She was transferred from a sitting position with the aid of a Sabina lift, which was a lift that required Resident #44 to be transferred from a sitting to a standing position. On 08/25/15 the care plan was updated for her to be transferred with a Viking lift, which transferred Resident #44 in a sitting position. The nurse's notes dated 08/19/15 indicated Resident #44 "passed out" when being transferred from the toilet back to her bed with the aid of the Sabina lift. The nurse's notes dated 08/23/15 revealed staff was called to Resident #44's room by a family member who stated	F 323	syncope events and to help prevent skin tears. On 8/25/15, the MDS nurse updated Resident #44¿s resident care plan and resident care guide to reflect the new changes. On 9/1/15, the assistant director of nursing/quality improvement nurse (ADON/QI) monitored and assisted nursing assistants with safe transferring of resident #44 on the Viking lift. On 8/25/15, Resident # 45 was discharged home after successful rehabilitation. On 8/27/15 the DON in-serviced the ADON/QI nurse on the importance of following the Safe Resident and Movement policy to ensure correct re-education and /or correct disciplinary actions are followed and to update resident care guides immediately to reflect current interventions. On 7/13/15, the ADON re-trained NA #4 and issued a disciplinary warning due to Resident #45¿s fall. The 7/13/15 re-training with NA # 4 included instruction to consult resident care guides before care and resident safety with transfers. On 7/24/15, the ADON re-trained NA #5 to consult the resident care guide before care and resident safety with transfers due to resident # 45¿s fall. NA # 5 employment was terminated.	

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F 323	Continued From page 10 Resident #44 had "passed out" while sitting up in a chair. A skin referral form dated 08/23/15 revealed Resident #44 had a new skin tear to her left shin. Review of the flowsheet for non-ulcer skin conditions dated 08/24/15 indicated Resident #44 had a 3 centimeter (cm.) skin tear to the left lower leg that was due to a syncopal (passing out) episode while in the Sabina lift. Resident #44 had a 4cm. x 5cm. hematoma to her left shin after a syncopal episode in the Sabina lift. Nurse's notes dated 8/25/15 and an incident report of the same date acknowledged Resident #44 had a syncopal episode when she was placed in a Sabina lift in an upright position and sustained a skin tear to her right lower leg. Non-ulcer skin condition flow sheets dated 08/25/15 indicated Resident #44 had a 4 cm. skin tear to her right shin after a syncopal episode in the Sabina lift and an L-shaped purple, hematoma above the skin tear. Non-ulcer skin condition sheets dated 08/27/15 indicated Resident #44 had 3 small skin tears to right lower leg. It also revealed she had a purple hematoma on the right lower leg and the 3 skin tears had opened up over the hematoma. On 08/24/15 at 10:32 AM an interview was conducted with Resident #44 after observations of bandages and bruises were made of her lower extremities. She indicated she had passed out in the Sabina lift. Resident #44 indicated this had been occurring for several days. On 08/26/15 at 10:50 AM an interview was conducted with Resident #44. She indicated she	F 323	On 9/10/15, the DON, ADON/QI nurse, MDS nurses, and/or therapy manager reviewed 100% of current resident care plans and resident care guides concerning transferring abilities and use of mechanical lifts. On 9/9/15, the ADON/QI nurse initiated in-servicing 100% of nursing staff on the Safe Resident Handling and Movement Policy. The in-service will be completed by 9/16/15. No nursing staff will be allowed to complete a work shift without completing the in-service on Safe Resident Handling and Movement Policy. On 9/14/15, the ADON/QI nurse and/or DON will begin random audits of nursing assistants for proper resident transfers. The ADON/QI nurse and/or DON will complete these audits 3 x week for 4 weeks, then 2 x week for 4 weeks, and then 1 x week for 4 weeks. The ADON/QI nurse and/or DON will immediately address any concerns and document re-education of the involved staff. The initial review for resident transfer abilities and need of mechanical lifts was 100% completed on 9/10/15. On 9/14/15, the MDS nurses and/or ADON will begin a 100% weekly review of resident transfer abilities and assignment of type of transfer, including mechanical lift assignment which will be reviewed by the ADON/QI nurse, MDS nurse and/or DON one time per week x 4 weeks, then bi-weekly x 4 weeks, and then once	

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F 323	Continued From page 11 had "several" incidences when she was gotten up in an upright position in the Sabina lift to help her with a transfer, and she would pass out. She indicated the syncopal episodes had begun the prior week, but she was not sure of the day. Resident #44 stated when she had the syncopal episodes in the Sabina lift, she would slide down in the lift and that caused her skin tears. She acknowledged her skin was very easy to bruise and tear. On 08/26/15 at 2:50 PM an interview was conducted with Nurse Aide #1 (NA#1). She stated she had taken care of Resident #44 since she came to the facility a couple of months earlier. She stated the NAs had been getting Resident #44 up in a Sabina lift, and she started having syncopal episodes. NA#1 indicated she wasn't sure when her first syncopal episode was, but she believed it was the prior week. She stated when Resident #44 was gotten up in the Sabina lift, she would black out until she was lowered back to a seated position. NA#1 acknowledged Resident #44 had several syncopal episodes on 08/24/15. She stated the first time it occurred Resident #44 was lowered back into her chair and she regained consciousness. She stated her vital signs were checked and her blood pressure was in the 90 over 50 range. NA#1 stated Nurse #2 was in the room at the time. NA#1 revealed she informed Nurse #2 that Resident #44 had blacked out again when gotten up in the Sabina lift the second time it occurred on 08/24/15. On 08/26/15 at 3:50 PM an interview was conducted with Nurse #2. She stated she was in Resident #44's room on 08/24/15 the first time she passed out. She indicated Resident #44 was gotten up in the Sabina lift and had a syncopal	F 323	monthly x 12 weeks. The ADON and/or DON will report the audit results at the weekly meeting of the QI committee (administrator, DON, ADON/QI, MDS nurses, treatment Nurse, and dietary manager). The ADON/QI nurse will also report the audit results and corrective actions taken to the monthly and quarterly Executive QA Committee (Medical director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager). Any recommended changes will be discussed and carried out as agreed upon.	

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episode and was returned to her chair. Nurse #2 indicated she was not aware if Resident #44 sustained any injuries or skin tears from this episode. She stated the second time Resident #44 had a syncopal episode on 08/24/15, she was called into the room by the nurse aides and she checked her vital signs. She stated she had a low blood pressure, but she didn't think that was anything different for Resident #44. Nurse #2 indicated she made the comment she thought the lift could be causing Resident #44's syncopal episodes, but she wasn't sure to whom she had commented. She stated she did not call the doctor on either occasion.

On 08/26/15 at 4:55 PM an interview was conducted with Nurse #1, who was the treatment nurse. She stated Resident #44's two skin tears on her left shin occurred on 08/24/15 during the syncopal episode in the Sabina Lift.

On 08/26/15 at 5:10 PM an interview was conducted with Nurse # 1 and Resident #44 during observation of dressing changes of the skin tears. Resident #44 was also observed at this time being transferred from her chair to the bed with the aid of a Viking lift. She stated she was comfortable in the lift and had no sense of passing out. Resident #44 acknowledged the hematoma on her left leg occurred on 08/25/15 after another syncopal episode in the Sabina lift. Nurse #1 confirmed the hematoma and skin tear to Resident #44's left leg were new occurrences identified after the 08/25/15 syncopal episode.

On 08/27/15 at 8:50 AM an interview was conducted with Nurse #3. He acknowledged on 08/25/15, NA#2 was assisting Resident #44 to the bathroom and had gotten her up in the Sabina

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lift when she had another syncopal episode. He stated NA#2 called for help and he responded and found she had been lowered back onto the toilet. He revealed she was returned to her bed and her vital signs were taken.

On 08/27/15 at 9:00 AM an interview was conducted with NA#2. He stated on 08/25/15 he was removing Resident #44 from the toilet with the Sabina lift when she had another syncopal episode. He revealed he got her up in the lift and she blacked out, slumping down in the lift and scraping her leg on the front of the lift. NA#2 indicated he called for assistance and Nurse #3 came and assisted him in getting Resident #44 back to the bed.

On 08/27/15 at 4:00 PM an interview was conducted with the Director of Nursing (DON). She indicated she was not informed Resident #44 was having syncopal episodes when gotten up in the Sabina lift until 08/25/15. She revealed she changed Resident #44 to a Viking lift with two person assist for transfers on 08/25/15 and sent a communication to the nurses at 11:14 AM. The DON acknowledged she would expect the staff to put the change in transfer orders in effect at the time it was communicated.

2. Resident #45 was admitted to the facility on 06/26/15 with diagnoses of hypertension, Alzheimer's disease, and non-Alzheimer's dementia. The admission Minimum Data Set (MDS) dated 07/03/15 indicated Resident #45 was cognitively intact. Resident #45 required extensive assistance with bed mobility, transfers,

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toilet use, dressing, and personal hygiene.

A record review of Resident #45's Care Area Assessment (CAA) dated 07/03/15 revealed Resident #45 had an increasing number of falls at home in the last 4 months. Resident #45 required extensive assistance with bed mobility, transfers, toileting, and locomotion on and off the unit, dressing, personal hygiene, and bathing. Resident #45 often required mechanical sit to stand lift for transfers related to bilateral lower extremity weakness.

On 08/24/15 at 11:48 AM an interview was conducted with Resident #45 who stated she was handled roughly by Nurse Aide (NA) while being transferred from wheelchair to the bed. Resident #45 stated the NA transferred her from the wheelchair to the bed alone and did not get extra help from the staff prior to transferring her. Resident #45 revealed she thought she was "man handled" by NA because the NA transferred her alone without using another staff person for assistance with the transfer. Resident #45 stated that on the back of her closet door was information for NA regarding her care. Resident #45 stated NA care information on the back of her closet door indicated she was to be transferred using the mechanical sit to stand lift.

A record review of Resident #45's nursing care plan dated 06/29/15 revealed Resident #45 had the following problem:

· Resident #45 required 2 person assistance with gait belt for transfers and staff could use mechanical sit to stand lift if Resident #45 was unable to stand and pivot.

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A record review was conducted of the NA care guide dated 06/29/15 which was provided by the Assistant Director of Nursing (ADON) and included the following interventions for transferring Resident #45. Resident #45 was to be transferred using 2 person assistance with gait belt or Resident #45 could be transferred using mechanical sit to stand lift if Resident #45 was unable to stand and pivot.

A record review of Resident #45's fall risk assessment score on 07/13/15 and 07/24/15 revealed a score of 13. A fall risk assessment total score of 10 or higher indicated Resident #45 was at risk for falls.

On 08/25/15 at 4:00 PM an interview was conducted with the ADON who stated Resident #45 fell on 07/12/15. The fall incident for Resident #45 was explained by the ADON as follows:

· On 07/12/15 at 6:44 AM Resident #45 had a fall while Nurse Aide (NA) #4 was transferring Resident #45 using 1 person assistance from the toilet to the wheelchair. ADON stated Resident #45 sat on the edge of the wheelchair and instead of scooting backwards in the wheelchair Resident #45 scooted forward and slid down onto the floor. ADON stated Resident #45 had no injuries as a result of the fall. ADON stated NA #4 was given a disciplinary warning because Resident #45's NA care guide indicated 2 person assistance with gait belt was required for transfers or mechanical sit to stand lift.

On 08/26/15 at 7:01 AM an interview was conducted with NA #4 who stated about 2 months ago Resident #45 rang for assistance to get off the toilet. NA #4 stated she used a gait belt and

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transferred Resident #45 using 1 person assistance from the toilet to the wheelchair. NA #4 stated Resident #45 did not sit all the way back in the wheelchair and slid onto the floor because NA #4 was unable to hold Resident #45 alone. NA #4 stated the nurse aide care guide on the back of Resident #45's closet door indicated Resident #45 was to be transferred using a gait belt with 2 person assistance. NA #4 stated she transferred Resident #45 using a gait belt and 1 person assistance. NA #4 stated she was retrained by the ADON on how to transfer Resident #45 and to follow nurse aide care guide for transfers.

On 8/26/15 at 1:17 PM an interview was conducted with Nurse #6 who stated NA #4 had transferred Resident #45 alone from the toilet to the wheelchair and Resident #45 slid to the floor. Nurse #6 stated Resident #45 was assessed and had no visible signs of injury. Nurse #6 stated Resident #45 denied pain or injury. Nurse #6 stated it was NA #4's responsibility to follow Resident #45's NA care guide for safe transfer.

A review of Resident #45's nursing care plan dated 06/29/15 revealed that it was updated on 07/15/15 to include Resident #45 required mechanical sit to stand lift with 1 to 2 persons for toileting and as needed. Resident #45 was to be shown how to position body parts when transferring and staff were to monitor Resident #45 for safety awareness. Resident #45 was to have call light in reach and answered timely by staff.

A record review was conducted of the NA care guide dated 6/29/15 and was updated on 07/15/15 to include Resident #45 could no longer

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be transferred using 2 person assistance with gait belt. Resident #45 was to be transferred using mechanical sit to stand lift with 1 to 2 person assistance with toileting and as needed for all transfers.

On 08/25/15 at 4:00 PM an interview was conducted with the ADON who stated Resident #45 fell again on 07/23/15. The fall incident for Resident #45 was explained by the ADON as follows:

· On 07/23/15 at 1:25 PM Resident #45 had a fall while NA #5 was transferring Resident #45 using 1 person assistance with pivot transfer from the wheelchair to the bed. During the 1 person assistance transfer, Resident #45 slumped facing forward from the wheelchair over onto the bed. NA #5 assisted Resident #45's knees onto the floor. ADON stated physical therapy came and helped turn Resident #45 to a sitting position on the floor and NA #5 and physical therapy assisted Resident #45 back into the bed. ADON stated Nurse #2 performed an assessment on Resident #45 which indicated no injury and Resident #45 could move all extremities per her usual. ADON stated prior to the fall incident on 07/23/15, Resident #45 was to be transferred using mechanical sit to stand lift for all transfers. ADON stated post Resident #45's fall, staff and Resident #45 were educated that mechanical sit to stand lift would be used for all transfers.

On 08/26/15 at 7:18 AM an interview was conducted with NA #5 who stated she assisted Resident #45 from the wheelchair to the bed using a gait belt and 1 person assistance. NA #5 stated as she was pivoting Resident #45 from the wheelchair to the bed, Resident #45 fell forward

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towards the bed. NA #5 stated she guided Resident #45 down onto the bed. NA #5 stated she required physical therapy assistance to place Resident #45 back into bed. NA #5 stated Resident #45's NA care guide indicated mechanical sit to stand lift was required for all transfers with 1 to 2 person assistance. NA #5 stated after Resident #45 fell, she used the mechanical sit to stand lift for all Resident #45's transfers.

On 08/26/15 at 9:50 AM an interview was conducted with Nurse #2 who stated Resident #45 fell in her room on 07/23/15 at 2:30 PM. Nurse #2 stated Resident #45 was found on her knees facing the bed and NA #5 was with Resident #45. Nurse #2 stated she was informed by NA #5 that Resident #45 started to fall when NA #5 was transferring Resident #45 alone back to bed. Nurse #2 stated Resident #45 required mechanical sit to stand lift for all transfers. Nurse #2 stated NA #5 had transferred Resident #45 alone without using the mechanical sit to stand lift. Nurse #2 stated Resident #45 had NA care plan that indicated Resident #45 required mechanical sit to stand lift for transfers. Nurse #2 stated she verbally informed NA #5 during morning shift report that Resident #45 required mechanical sit to stand lift for all transfers and was not safe to transfer Resident #45 without using mechanical sit to stand lift.

On 08/26/15 at 11:13 AM an interview was conducted with ADON who stated her expectations were that the fall could have been avoided if NA #4 had followed Resident #45's NA care guide on 07/12/15 and used 2 person assistance rather than 1 person assistance with transferring Resident #45. ADON stated the

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intervention on the care guide prior to Resident #45's fall on 07/12/15 indicated 2 person assist with gait belt or use mechanical sit to stand lift if Resident #45 was unable to stand and pivot. ADON stated after Resident #45's fall on 07/12/15 the NA care guide was updated and new intervention indicated mechanical sit to stand lift was required for all Resident #45's transfers. ADON stated a computerized message was posted for staff to read when computer was accessed by the staff that alerted staff that Resident #45 required mechanical sit to stand lift for all transfers

On 08/26/15 at 11:13 AM an interview was conducted with ADON who stated her expectations were that NA #5 would have followed Resident #45's NA care guide for safe transfers. ADON stated on 07/23/15 Resident #45's care guide indicated mechanical sit to stand lift was required for all transfers. ADON stated a staff in-service was conducted on 07/23/15 which indicated staff were required to follow Resident #45's NA care guide interventions for safe transfers.

On 08/27/15 at 7:31 AM an interview was conducted with the Director of Nursing (DON) who stated her expectations were that nurse aides would have followed Resident #45's NA care guide for safe transfers. DON stated after Resident #45 had 2 falls the staff were in-serviced on safe transferring of residents and reviewing and following resident care guides because care guides were constantly updated. DON stated the individual nurse aides involved in the unsafe transfer of Resident #45 were disciplined and provided 1 on 1 in-service on safe transfer of Resident #45 and to follow resident NA

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F 323	Continued From page 20 care guide.	F 323		
F 371 SS=E	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 observation and staff interviews the facility failed to date and label food that was removed from the original labeled packaging container and stored in 1 of 1 kitchen walk-in freezer. The findings included: On 08/24/15 at 7:31 AM an initial tour of the kitchen was conducted with the Dietary Manager. Observation of the kitchen walk-in freezer revealed 1 clear sealed plastic bag of unidentified, unlabeled, and undated breaded frozen food product (approximately 20 individual pieces) that was out of the original labeled packaging container and was available for resident use. Dietary Manager stated unidentified breaded frozen food product was apple fritters and staff would not have known type of food product because it was unlabeled. Dietary Manager immediately removed the unlabeled and	F 371	F371: On 8/24/15, the dietary manager immediately removed the Apple battered Crescent bag from the freezer and discarded in the trash receptacle. On 9/3/15, the dietary manager completed a 100% in-service with dietary staff to check expiration dates and labeling, to make sure expired items are discarded, and to make sure items are labeled with names and dates to include freezer items. On 9/3/15, the dietary manager initiated a monitoring checklist/auditing tool for all food storage areas to be completed daily x 4 weeks, then 5 days a week x 8 weeks, then once a week thereafter to ensure proper labeling and dating of food items is provided.	9/16/15

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F 371	Continued From page 21 undated frozen breaded food product from the kitchen walk-in freezer for discard. On 08/25/15 at 7:30 AM an interview was conducted with Dietary Manager who stated food was dated when entered into the kitchen from supplier and was dated when it was opened. Dietary Manager revealed during dietary shift change food was checked for outdates, labeling, and food was discarded if indicated. Dietary Manager stated it was an oversight that the unidentified breaded frozen food in the kitchen walk-in freezer was not labeled and dated when it was removed from the original packaging container. On 08/26/15 at 8:32 AM an interview was conducted with Dietary Manager who stated the facility did not have a policy for dating and labeling frozen food that was removed from the original packaging container. On 08/27/15 at 8:12 AM an interview was conducted with the Administrator who stated he had no expectations for dietary staff for the unidentified, unlabeled, and undated breaded frozen food stored in the kitchen walk-in freezer that was ready for resident use because the facility had no corporate policy for labeling and dating frozen food that was removed from the original packaging container and stored in the kitchen walk-in freezer.	F 371	The Dietary Manager will present the completed auditing tool to the QI/ADON. The dietary manager and/or QI/ADON nurse will report the dietary audit results at the weekly meeting of the QI committee (administrator, DON, ADON/QI, MDS nurses, treatment Nurse, and dietary manager). The ADON/QI nurse will report the audit results and corrective actions taken to the monthly and quarterly Executive QA committee (Medical Director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager). Any recommended changes will be discussed and carried out as agreed upon.	
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	F 441		9/16/15

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	345396	A. BUILDING _____ B. WING _____	C 08/27/2015

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F 441	Continued From page 22 to help prevent the development and transmission 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 observations, record review and staff interview the facility failed to observe correct infection control practices to avoid the risk of	F 441	F441: On 8/28/15, the treatment nurse initiated	

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F 441	Continued From page 23 cross contamination between residents by not sanitizing scissors after use and failed to avoid the risk of cross contamination between 2 different wounds for 1 of 4 residents observed for wound care. (Resident # 2). The findings included: Review of a facility policy titled "Handwashing Policy" from the Infection Control Manual dated September 2014 read in part: "Personnel should wash their hands before and after touching wounds; when indicated between tasks and procedures to prevent cross contamination of different body sites." Observation was made on 08/27/15 at 10:43 AM of Nurse #1 providing wound care for Resident #2. Nurse #1 sanitized her hands and donned gloves then removed the dressing covering a wound on Resident #2's left lower leg. She then cleansed the wound, applied skin prep to the periwound area and applied a new bordered gauze dressing. Without changing gloves or washing her hands, Nurse #1 then removed a dressing from Resident #2's right hand. Nurse #1 cleaned the area with a gauze soaked with normal saline and patted it dry. Nurse #1 then removed her gloves and sanitized her hands. Nurse #1 removed a non-stick dressing from the package, took scissors from her pocket and cut the bandage to fit the size of the wound and placed the scissors on the table with the other wound care supplies. Nurse #1 then donned gloves, applied skin prep to the periwound area, applied the non-stick dressing to the wound and covered it with a non-occlusive dressing. Nurse #1 then returned the scissors to her pocket. Nurse #1 collected the soiled and unused	F 441	monitoring Resident #2s every dressing change to ensure no adverse reactions/infections have occurred due to break in infection control protocol. Starting 8/28/15, the treatment nurse and/or nurse in charge will document monitoring in Treatment Administration Record for 10 days, ending on 9/6/15. On 9/3/15, the ADON/QI nurse in-serviced Nurse #1 on handwashing technique, proper procedures for dressing change, avoiding cross contamination, and to sanitize scissors before and after use. The ADON/QI nurse (SPICE Certified) initiated in-servicing 100% of all staff on handwashing policy and to wash hands before and after gloving. The in-service will be completed by 9/14/15. No nursing staff will be allowed to complete a work shift without completing the handwashing in-service. The ADON/QI nurse and/or the DON will train all new employees during orientation on the infection control and handwashing policy. The ADON/QI nurse and/or DON will in-service all employees once monthly for 4 months on infection control and handwashing, then routinely twice a year and as needed. On 9/14/15, the ADON/QI nurse and/or DON will begin random audits of all staff working in the facility for proper handwashing technique, including when to hand wash. The ADON/QI nurse and/or DON will complete these audits 5 x week for 4 weeks, then 2 x week for 4 weeks, and then 1 x week for 4 weeks. The	

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F 441	Continued From page 24 supplies in a bag, tied the top of the bag, washed her hands, removed the trash from the resident's room and sanitized her hands. Nurse #1 was not observed sanitizing her scissors before or after use. An interview on 08/27/15 at 11:04 AM with Nurse #1 revealed she was trained to sanitize or wash her hands before beginning a dressing change, don gloves, remove the dressing and clean the wound then change gloves before applying the new dressing. Nurse #1 stated she should change gloves and wash her hands before treating wounds on different parts of a resident's body. Nurse #1 stated she didn't notice that she failed to change gloves before moving from the dressing change on Resident #2's leg to the dressing change on her hand. When asked what the expectation was for sanitizing her scissors, she stated they should be sanitized before use and between residents. Nurse #1 stated she cleaned her scissors at the beginning of the shift but forgot to clean them after using them when doing Resident #2's wound care. An interview on 08/27/15 at 1:44 PM with the Director of Nursing (DON) about her expectation for wound care revealed she expected the nurses to wash their hands before doing a treatment, remove the soiled dressing, clean the wound, remove the gloves, wash their hands, don new gloves and apply the clean dressing. The DON stated gloves should be changed and hands washed between different wounds. The DON stated she expected the nurses to wash their hands after completing a dressing change before leaving the resident's room. A second interview on 08/27/15 at 5:06 PM with	F 441	ADON/QI nurse and/or DON will immediately address any concerns and document re-education of the involved staff. The ADON and/or DON will report the audit results at the weekly meeting of the QI committee (administrator, DON, ADON/QI, MDS nurses, treatment Nurse, and dietary manager). The ADON/QI nurse will also report the audit results and corrective actions taken to the monthly and quarterly Executive QA Committee (Medical director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager). Any recommended changes will be discussed and carried out as agreed upon.	

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F 441	Continued From page 25 the DON revealed she was not sure Nurse #1 knew she was expected to sanitize her scissors after each use when doing wound care. The DON stated she thought Nurse #1 got nervous and forgot to follow correct infection control procedures. The DON stated she had observed Nurse #1 doing wound care on several occasions and had not seen any infection control concerns.	F 441		
F 520 SS=E	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. This REQUIREMENT is not met as evidenced	F 520		9/16/15

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F 520	Continued From page 26 by: Based on observations, staff interviews and record review the facility's Quality Assessment and Assurance (QA and A) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in July of 2014. This was for two deficiencies that were cited in July 2014 on a Recertification survey. These deficiencies were re-cited on the current recertification survey. The deficiencies were in the areas of Food Procurement, Storage, Preparation and Distribution and Infection Control. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F 371: Food Procurement, Storage, Preparation and Distribution: Based on observation and staff interviews the facility failed to date and label food that was removed from the original labeled packaging container and stored in the kitchen walk-in freezer. During the recertification survey of July 2014, the facility was cited for F 371 for staff failing to wash hands after removing gloves when going from a dirty task to a clean task in the kitchen. On the current survey the facility was cited for failing to label and date a clear sealed plastic bag of breaded, frozen food product that had been removed from the original labeled packaging container and was stored in the kitchen's walk-in freezer.	F 520	F520: On, 9/14/15 the corporate nursing consultant will in-service the dietary manager and Administrator on the Quality Assurance (QA) process, to include implementation of action plans, monitoring tools, the evaluation of the QA process, and modification and correction if needed. On 9/14/15 the corporate consultant will in-service the administrator, DON, and ADON/QI nurse on the QA process to include identifying issues that warrant development and implementation of action plans to ensure that practices are applied to meet quality standards, establishing a system to monitor the corrections and review of the monitoring tools through QA meetings to evaluate outcomes. The Executive QI committee (Medical director, administrator, DON, ADON/QI, MDS nurses, treatment nurse, dietary manager) had a called meeting on 9/10/15 to discuss the plan of correction concerning dietary and infection control. The committee determined a copy of the dietary plan of correction in-services and auditing tools will be kept in a separate folder and will be monitored weekly, monthly, and quarterly by the QI committee. Monitoring of the QA dietary tool and an independent audit will be completed by the Maintenance manager and/or housekeeping supervisor and	

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F 520	Continued From page 27 F 441: Infection Control Program: Based on observations, record review and staff interviews the facility failed to observe correct infection control practices to avoid the risk of cross contamination between residents by not sanitizing scissors after use and failed to avoid the risk of cross contamination between 2 different wounds for 1 of 4 residents observed for wound care. During the recertification survey of July 2014, the facility was cited for F 441 for failing to bag dirty linen prior to transporting dirty linen in the hallway. On the current survey the facility was cited for failing to sanitize scissors after use while doing wound care and failing to change gloves and wash hands between doing treatment to 2 different wounds on different areas of a resident's body. During an interview on 08/27/15 at 5:06 PM the Director of Nursing (DON) stated the facility had continued to monitor both areas since the last recertification survey. The DON stated the Administrator monitored the kitchen and had not reported any problems during the monthly QA and A committee meetings. She also stated that she and the infection control nurse monitored staff for compliance with the infection control policies and had identified a concern which was addressed with staff through re-education. The DON stated she had monitored wound care and had not identified any concerns. The DON stated she thought Nurse #1 was nervous and forgot to change gloves as she should have. She stated she wasn't sure Nurse #1 was aware that she should sanitize her scissors.	F 520	recorded on the Label Checklist monitoring tool 2 x weekly for 4 weeks and weekly for 3 months thereafter and be presented to Administrator, Chairman of the QA committee for review and signature. A copy of the infection control handwashing plan of correction in-services and auditing tools will be kept in a separate folder and will be monitored weekly, monthly, and quarterly by the QI committee. Additional monitoring of the Handwashing audit tool and an independent audit will be completed by the MDS nurse and/or Administrative nurse and recorded on the Overview Handwashing monitoring tool 2 x weekly for 4 weeks and weekly for 3 months thereafter and be presented to Administrator, Chairman of the QA committee for review and signature. Monthly monitoring of the QA process and implementation of dietary and infection control action plans will be documented by the Administrator/ DON using the QA Process Monitoring Tool during monthly and quarterly QA meetings for 6 months to determine if the QA process is effectively identifying quality deficiencies and/or potential trends.	