STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT THOMASVILLE	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide privacy during care by not pulling the privacy curtain between residents for 1 (Resident #41) of 3 sampled residents observed during care. Findings included:	F 164	F 164 Deficiency corrected 1. Corrective action has been accomplished for the alleged deficient practice in regards to providing privacy during care. The Director of Nursing	12/2/15

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

Electronically Signed | 11/25/2015

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F 164	Continued From page 1 Resident #41 was admitted to the facility on 8/5/14 with multiple diagnoses including pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 10/13/15 indicated that Resident #41's cognition was intact and had a stage III pressure ulcer. The care plan dated 9/2/15 indicated that Resident #41 had a stage III pressure ulcers on the sacrum and left buttock. On 11/3/15 at 1:05 PM, Resident #41 was observed during a dressing change. When Resident #41 turned to her right side, the resident's buttocks area was exposed. The privacy curtain between the resident's beds was not pulled. The roommate was in her bed and the resident's buttocks area was visible to the roommate. On 11/3/15 at 1:13 PM, Nurse #3, the nurse who provided the treatment, was interviewed. She stated that she forgot to pull the privacy curtain and agreed that Resident #41's buttocks was exposed to her roommate. On 11/4/15 at 3:50 PM, administrative staff #1 was interviewed. She stated that she expected Nurse #3 to provide privacy by pulling the privacy curtain between the beds during care.	F 164	provided in service education with Nurse # 3 on 11/03/2015, regarding the expectation of staff to provide privacy by pulling the privacy curtain between residents when providing care/services. 2. Current facility residents have the potential to be affected by the alleged deficient practice. On 12/01/2015 the Director of Nursing and 3rd shift RN completed privacy audits on all shifts. 3. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing began in-service education on 11/20/2015, regarding “providing resident privacy and confidentiality during care/services.” On 12/01/2015 the Director of Nursing and 3rd shift RN completed random observational privacy audits on all shifts. The Director of Nursing and HR manger will ensure providing resident privacy education be included upon new-hire orientation and annually. The Director of Nursing and/or Unit Coordinator will observe 2 residents during wound-care and/or resident care 3 times a week for 4 weeks, weekly for 4 weeks, and every other week for 4 weeks, and then monthly for 3 months to include all shifts and weekends, to validate privacy is provided during care services. 4. The results from the random-audits reviewed daily/PRN by the Director of Nursing to analyze observations for	

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F 164	Continued From page 2	F 164	patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
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.	F 280		12/2/15

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and revise the care plan to reflect the discontinuation of a right hand splint for one of three residents (Resident #23) reviewed for range of motion. The findings included: Resident #23 was originally admitted to the facility on 8/12/05 and was readmitted on 3/29/12 with multiple diagnoses including history of cerebrovascular accident (CVA) with upper extremity weakness and contracture of hand joint. The quarterly Minimum Data Set (MDS) assessment dated 8/17/15 indicated the resident was cognitively intact, had a functional limitation in range of motion on one side of the upper extremity, and was in the restorative nursing program for active range of motion (AROM), passive range of motion (PROM), and splint or brace assistance. A review of Resident #23's care plan revealed an intervention that indicated a splint was applied to his right hand after morning care and removed at lunch time six days per week. A review of the restorative nursing documentation revealed a note dated 9/1/15 that indicated Resident #23 was discharged from restorative nursing due to his refusal to participate. A review of the physician orders revealed an order dated 9/4/15 that indicated Resident #23 was discharged from restorative nursing due to his refusal to participate. An interview was conducted with Nurse #3 on 11/2/15 at 2:55PM. She stated that the resident had a right hand contracture and did not wear a splint. An interview was conducted with Administrative	F 280	F 280 Deficiency corrected 1.Corrective action has been accomplished for the alleged deficient practice in regards to care plan revision for Resident #23. The MDS coordinator reviewed and updated the care plan for Resident #23 on 11/12/2015, to reflect the discontinuation of splinting. 2. Current facility residents have the potential of being affected by the alleged deficient practice. The DON and/or the MDS coordinator completed an audit on 11/11/15, of current physician orders and compared to residents identified that are receiving restorative services , to identify active and/or discontinued restorative services and validated that care plans are up to date with current orders. 3.Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Clinical Reimbursement/MDS, RN RAC-CT provided in-service education to the MDS coordinator and Director of Nursing on 11/13/2015, regarding reviewing and updating care plans to support the needs and care of the resident. The MDS coordinator will review telephone orders daily to identify new or discontinued restorative services and will update care plan as needed. The DON will review restorative orders and care	

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F 280	Continued From page 4 Staff #2 on 11/4/15 at 12:22PM. She stated that she was responsible for revising care plans. She reviewed Resident #23's care plan and physician orders. She revealed that the care plan was not accurate. She stated that the right hand splint for Resident #23 was discontinued on 9/4/15 when he was discharged from restorative nursing. She stated that she should have updated the care plan on 9/4/15 to remove the intervention for the right hand splint. She stated that this was a mistake.	F 280	plan updates weekly for four weeks then monthly for 3 months to validate care plans are updated when orders are written. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, resident and staff interviews, the facility failed to provide nail care to five of five residents who required extensive	F 312	F 312 Deficiency corrected 1.Corrective action has been accomplished for the alleged deficient	12/2/15

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F 312	Continued From page 5 assistance and/or were dependent on staff for personal hygiene (Resident #66, #55, #10, #19 and #2). The findings included: 1. Resident #66 was admitted to the facility 5/1/14. Cumulative diagnoses included cerebrovascular accident with hemiplegia on dominant side, contracture of the hand and diabetes. A Quarterly Minimum Data Set (MDS) dated 10/23/15 indicated Resident #66 had short term and long term memory impairment and severely impaired in decision-making. He required total care with personal hygiene and bathing. A care plan dated 5/13/15 and last reviewed 10/16/15 indicated Resident #66 had an ADL (activities of daily living) performance deficit related to hemiplegia. Interventions included, in part, that Resident #66 was totally dependent on staff for personal hygiene and oral care. A facility policy titled "Care of fingernails/toenails" last revised on October 2010 stated, in part, "1. Nail care includes daily cleaning and regular trimming." On 11/2/15 at 4:02PM, Resident #66 was observed to have elongated fingernails on both hands. Fingernails were approximately ¼ inch long and there was black material under each nail. On 11/3/15 at 9:50AM, an observation of Resident #66 revealed Resident #66 continued to have elongated fingernails and black material was noted under each nail.	F 312	practice in regards to provision of nail care for dependent residents. Nail care was provided for Residents #66, #55, #10, #19 and #2 on 11/04/2015. 2.Current facility residents dependent on staff for provision of care have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) and unit coordinator provided in service education for nursing staff beginning 11/04/2015 regarding Provision of care for dependent residents, including nail care. The DON and unit coordinator observed current facility residents to identify needs for nail care, and provided nail care to those identified. 3.Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing (DON) and unit coordinator provided in service education for nursing staff beginning 11/04/2015, regarding Provision of care for dependent residents, including nail care. The DON and/or unit coordinator will observe 5 residents weekly for four weeks, then 5 residents monthly for four weeks to validate that nail care has been provided as needed. 4.The Director of Nursing will analyze observation reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.	

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F 312	Continued From page 6 On 11/4/15 at 9:20AM, Resident #66 was observed receiving morning care by NA#1 and NA#2. Both NA#1 and NA#2 stated Resident #66 required total ADL care by nursing staff. NA#1 and NA#2 completed morning care. NA#1 washed and dried Resident #66 ' s hands. No nail care was performed during the morning care. When asked what was included in daily morning care, both NA#1 and NA#2 stated morning care included bathing, mouth care, grooming which included shaving, hair care and nail care. They stated they cleaned under the fingernails and clipped nails if they were not diabetic. If the resident was diabetic, they cleaned under the fingernails and notified the nurse so the nails could be clipped/ trimmed. Both NA#1 and NA#2 observed Resident #66's fingernails and indicated they should have been cleaned and clipped and they had overlooked the nail care. They stated they would clean under the fingernails and notify the nurse that the nails needed to be clipped. On 11/4/15 at 10:00AM, an observation was conducted with Administrative staff #1 who stated Resident #66 needed to have his fingernails cleaned and trimmed. On 11/4/15 at 11:20AM, Nurse #1 stated she had been at the facility since the middle of October and worked Monday through Friday. Nurse #1 provided care for Resident #66. She stated, if a resident was diabetic, licensed staff would clip/ trim the nails (fingernails/ toes). She stated she had not been informed by any nursing staff that any of the residents needed to have their fingernails clipped/ trimmed. On 11/4/15 at 120PM, Administrative staff #1 stated she expected staff to trim fingernails and	F 312	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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clean under nails and the fingernails she observed were unacceptable.

2. Resident #55 was admitted to the facility 2/3/12. Cumulative diagnoses included cerebrovascular accident with hemiplegia on the dominant side and cognitive deficit.

An Annual MDS dated 10/9/15 indicated Resident #55 had short term and long term memory impairment and was moderately impaired with daily decision-making. Extensive assistance was required for personal hygiene and bathing.

A care plan last reviewed 8/12/15 indicated Resident #55 had a self-care performance deficit due to hemiplegia. Interventions included, in part, extensive assistance for repositioning and total assistance for incontinent care.

A facility policy titled "Care of fingernails/toenails" last revised on October 2010 stated, in part, "1. Nail care includes daily cleaning and regular trimming."

An observation conducted on 11/2/15 at 4:29PM revealed Resident #55 had black material under all of the fingernails and all of the fingernails were elongated about 1/4 inch.

On 11/3/15 at 9:53AM, an observation of Resident#55 revealed the fingernails continued to be elongated and black material was noted under each nail.

On 11/4/15 at 9:55AM, an observation was conducted and revealed Resident #55's fingernails remained elongated and black material was noted under each nail.

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On 11/4/15 at 10:00AM, an observation was conducted with Administrative staff #1 who stated Resident #55 needed to have his fingernails cleaned and trimmed.

On 11/4/15 at 11:20AM, Nurse #1 stated she had been at the facility since the middle of October and worked Monday through Friday. Nurse #1 provided care for Resident #55. She stated, if a resident was diabetic, licensed staff would clip/ trim the nails (fingernails/ toes). She stated she had not been informed by any nursing staff that any of the residents needed to have their fingernails clipped/ trimmed.

On 11/4/15 at 1:20PM, Administrative staff #1 stated she expected staff to trim fingernails and clean under nails and the fingernails she observed were unacceptable.

On 11/04/2015 at 3:15PM, NA#3 stated Resident #55 was total care with ADL's. She stated Resident #55 resisted care at times but he allowed staff to clean and trim his nails today without any problem.

3. Resident #10 was admitted to the facility 3/30/2001. Cumulative diagnoses included cerebrovascular accident with left hemiplegia.

A Quarterly MDS dated 8/26/15 indicated Resident #10 was severely impaired in cognition. He required extensive assistance with personal hygiene and bathing.

A care plan last reviewed 9/25/15 indicated Resident #10 had an ADL self-care performance deficit related to hemiplegia. Interventions

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included, in part, that Resident #10 required extensive assistance with toileting and incontinent care.

A facility policy titled "Care of fingernails/toenails" last revised on October 2010 stated, in part, "1. Nail care includes daily cleaning and regular trimming."

On 11/2/15 at 3:51PM, Resident #10 was observed to have elongated fingernails on both hands. Fingernails were approximately ¼ inch long and there was black material under each nail.

On 11/3/15 at 9:52AM, an observation of Resident #10 revealed Resident #10 continued to have elongated fingernails and black material was noted under each nail.

On 11/4/15 at 9:30AM, an observation of Resident #10 revealed Resident #10 continued to have elongated fingernails and black material under each nail.

On 11/4/15 at 10:00AM, an observation was conducted with Administrative staff #1 who stated Resident #10 needed to have his fingernails cleaned and trimmed. She stated they would be done today.

On 11/4/15 at 11:20AM, Nurse #1 stated she had been at the facility since the middle of October and worked Monday through Friday. Nurse #1 provided care for Resident #10. She stated, if a resident was diabetic, licensed staff would clip/ trim the nails (fingernails/ toes). She stated she had not been informed by any nursing staff that any of the residents needed to have their

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fingernails clipped/ trimmed.

On 11/4/15 at 1:20PM, Administrative staff #1 stated she expected staff to trim fingernails and clean under nails and the fingernails she observed were unacceptable.

On 11/4/15 at 3:15PM, NA#3 stated Resident #10 required assistance with grooming and required staff to perform nail/ hand care.

4. Resident #19 was admitted to the facility 8/21/15. Cumulative diagnoses included diabetes mellitus.

An Admission MDS dated 8/28/15 indicated Resident #19 was cognitively intact. He required extensive assistance with personal hygiene and bathing.

A care plan dated 9/8/15 stated Resident #19 required assistance with ADL's. Interventions included, in part, to assist as needed for completion of ADL's.

A facility policy titled "Care of fingernails/toenails" last revised on October 2010 stated, in part, "1. Nail care includes daily cleaning and regular trimming."

On 11/2/15 at 4:20PM, Resident #19 was noted to have elongated nails approximately ¼ inch long on both hands and black material under nails. Resident #19 stated he did not like them that long and they needed to be cut/ cleaned. He stated he had not asked anyone to cut them recently.

On 11/3/15 at 9:53AM, an observation of Resident #19 was conducted. The fingernails on

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both hands remained elongated with black material under each nail. Resident #19 stated no one had provided care for his fingernails.

On 11/4/15 at 10:00AM, an observation of Resident #19 was conducted. The fingernails on both hands remained elongated with black material under each nail. Resident #19 stated no one had provided care for his nails and he did not know who to ask about them.

On 11/4/15 at 10:00AM, an observation was conducted with Administrative staff #1 who stated Resident #19 needed to have his fingernails cleaned and trimmed. She told Resident #19 his nails would be cleaned and trimmed that day.

On 11/4/15 at 11:20AM, Nurse #1 stated she had been at the facility since the middle of October and worked Monday through Friday. Nurse #1 provided care for Resident #19. She stated, if a resident was diabetic, licensed staff would clip/ trim the nails (fingernails/ toes). She stated she had not been informed by any nursing staff that any of the residents needed to have their fingernails clipped/ trimmed.

On 11/4/15 at 1:20PM, Administrative staff #1 stated she expected staff to trim fingernails and clean under nails and the fingernails she observed were unacceptable.

On 11/4/15 at 3:15PM, NA#3 stated Resident #19 required staff to do care for his fingernails/ trim nails.

5. Resident #2 was admitted to the facility 2/17/2006. Cumulative diagnoses included cerebrovascular accident with right hemiplegia.

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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 312	Continued From page 12	F 312		

A Quarterly MDS dated 9/30/15 indicated Resident #2 had short and long term memory impairment and was moderately impaired in decision-making. He required extensive assistance with personal hygiene and bathing.

A care plan last reviewed on 9/15/15 indicated Resident #2 had an ADL self-care performance deficit related to hemiplegia. Interventions included, in part, that Resident #2 was totally dependent on staff for transfers and incontinent care.

A facility policy titled "Care of fingernails/toenails" last revised on October 2010 stated, in part, "1. Nail care includes daily cleaning and regular trimming."

On 11/2/15 at 3:40PM, Resident #2 was observed to have all fingernails on both hands elongated approximately ¼ inch and black material was noted under each nail. Resident #2 stated he did not like them that way.

An observation of Resident #2 was conducted on 11/3/15 at 9:52AM. His nails remained elongated with black material under each nail. Resident #2 stated nursing staff do nails now and then.

On 11/4/15 at 10:00AM, an observation of Resident #2 revealed his fingernails remained elongated with black material under each nail.

On 11/4/15 at 10:00AM, an observation was conducted with Administrative staff #1 who stated Resident #2 needed to have his fingernails cleaned and trimmed. She told Resident #2 his nails would be cleaned and trimmed that day.

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	345520	A. BUILDING _____ B. WING _____	11/04/2015

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F 312	Continued From page 13 On 11/4/15 at 11:20AM, Nurse #1 stated she had been at the facility since the middle of October and worked Monday through Friday. Nurse #1 provided care for Resident #2. She stated, if a resident was diabetic, licensed staff would clip/ trim the nails (fingernails/ toes). She stated she had not been informed by any nursing staff that any of the residents needed to have their fingernails clipped/ trimmed. On 11/4/15 at 1:20PM, Administrative staff #1 stated she expected staff to trim fingernails and clean under nails and the fingernails she observed were unacceptable. On 11/4/15 at 3:15PM, NA#3 stated Resident #2 was total care and required staff to perform all nail care.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess a pressure ulcer for 1 of 3 residents (Resident #52). Findings included:	F 314	F 314 Deficiency corrected 1.Corrective action has been	12/2/15

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F 314	Continued From page 14 Resident #52 was admitted 7/25/15 with diagnoses including Alzheimer's disease and abnormal involuntary movements. The Admission Minimum Data Set (MDS) indicated Resident #52 was cognitively intact and did not have a pressure ulcer. Review of the Progress Notes revealed a Skin Assessment dated 8/9/15 that indicated Resident #52 had 3 small open areas on her left buttock and that treatment was initiated according to the facility wound care protocol, with a note for the physician to review. There were no notes indicating the wound measurements or that described the condition of the wounds. Nurse #2, who wrote the note was not available for interview. The Care Plan was updated on 8/12/15 and revealed a new care plan for risk of pressure ulcers due to fragile skin. Interventions included treatment per orders to left buttock, notify physician of changes and pressure relieving device on bed. Resident #52 was discharged home on 8/13/15. On 11/4/15 at 3:57 PM Administrative Staff #2 stated that she and Administrative Staff #1 had looked in the Medical Record and in the previous Treatment Nurse's office and were unable to locate an assessment for Resident #52's pressure ulcers. She added that it was her expectation that an assessment of the resident's pressure ulcer should have been completed when the wound was identified.	F 314	accomplished for the alleged deficient practice in regards to Resident #52. Resident #52 was discharged home on 8/13/15. 2.Current facility residents have the potential to be affected the same deficient practice. The Director of Nursing provided in service education for the licensed nurses beginning 11/10/2015, regarding Assessment and documentation of wounds upon admission/readmission, and/or when a new wound is identified. The DON, unit coordinator and licensed nurses began skin assessments on current residents on 11/10/2015, to identify residents with wounds and validate measurements, documentation and treatment orders have been initiated. (if any were identified) Documentation, measurements, treatments were initiated, and physician/family were notified for discrepancies that were identified. (if none were identified) There were no discrepancies identified. 3. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing provided in service education for the licensed nurses beginning 11/10/2015 regarding Assessment and documentation of wounds upon admission/readmission, and/or when a new wound is identified. The Director of Nursing and/or the unit coordinator will review new	

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F 314	Continued From page 15	F 314	admission/readmission charts during daily clinical review at least 5 times per week, to validate skin assessments are completed and wound measurements and treatments are initiated as needed. The DON will observe/review 2 new admissions or readmission residents skin, weekly for four weeks, then 2 residents monthly to validate skin assessment accuracy and documentation to support assessment. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		12/2/15

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F 318	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to consistently apply the bilateral hand splints and to provide the passive range of motion six times a week as ordered for 1 (Resident #21) of 3 sampled residents with limited range of motion. Findings included: Resident #21 was admitted to the facility on 3/12/07 with multiple diagnoses including Alzheimer's disease and hypertension. The Minimum Data (MDS) assessment dated 10/2/15 indicated that Resident #21 had memory and decision making problems and had limitation in range of motion on both sides of the upper extremities. The assessment also indicated that Resident #21 had received passive range of motion (PROM) and splint/brace assistance for 4 days in the last 7 calendar days by the restorative nursing program. The occupational therapy (OT) notes were reviewed. The notes dated 7/6/15 indicated that Resident #21 was referred due to the contracture and tear on her left hand. Resident #21 was evaluated and treated to fit for orthotic device, facilitate splinting tolerance, assess safety with splinting device and instruct in scheduling/care of new device. On 7/17/15, Resident #21 was discharged from OT services to restorative nursing program for PROM and splint application. On 7/20/15, there was a telephone order for	F 318	F 318 Deficiency corrected 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #21. Resident # 21 was re-evaluated by Occupational Therapy on 11/10/2015, with recommendation to continue restorative/splinting services. Resident #21 will continue Restorative services for ROM and splinting 6 x/week. 2. Current residents receiving restorative services for ROM and splinting have the potential to be affected by the alleged deficient practice. The DON, MDS coordinator and/or Therapy manager began in-service education for restorative aides on 11/06/2015, regarding providing services as ordered and/or according to care plan. The Director of Nursing (DON), MDS coordinator and Therapy program manager audited/reviewed the residents records that have orders for restorative services for ROM and splinting, to validate that services remain necessary and/or appropriate, and residents are receiving services as ordered. The physician was notified regarding discrepancies identified and services were initiated as ordered. 3. Measures put into place to ensure the	

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F 318	Continued From page 17 restorative nursing to provide PROM to both upper extremities with leeder grip hand splint on left hand and resting hand splint on the right hand, on after AM care and off with PM care 6 times per week. The care plan dated 10/2/15 was reviewed. One of the care plan problems was alteration in musculoskeletal status related to contractures of the right and left hands, restorative nursing for passive range of motion and bilateral hand splints. The goal was to remain free of injuries or complications related to right and left contractures and to have no further progression of contractures through the next review date. The approaches included keep both hands clean and dry, monitor right and left hands for skin breakdown and passive range of motion given per order and splints applied to bilateral hands per orders. On 11/4/15 at 8:15 AM, Resident #21 was observed up in a Geri chair with bilateral hand splints on. The monthly restorative care flow records were reviewed. The July, 2015 record revealed that Resident #21 was provided the restorative nursing program (PROM and application of splints) 5 times per week instead of 6 times per week as ordered. The week of July 20 - 25, the resident received the restorative nursing program on July 20-24. The week of July 27- Aug 1, the resident received the restorative nursing program on July 27-31. The week of August 2-8, the resident received	F 318	alleged deficient practice does not recur include: The DON, MDS coordinator and/or Therapy manager began in-service education for restorative aides on 11/06/2015, regarding providing services as ordered and/or according to care plan. The DON and/or MDS coordinator will review the restorative grid for services rendered to at least 5 residents, 5 times a week for four weeks then 5 residents monthly for four weeks, to include all shifts and weekends, to validate services are provided as ordered and/or per care plan. The MDS coordinator and Therapy program manager will review/observe the residents that are receiving restorative services weekly/monthly to validate documentation and provision of services have occurred as recommended and continued services are needed and update care plan and orders as necessary. 4. The Director of Nursing will analyze audits/reviews for patterns/trends qday/PRN and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because	

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F 318	Continued From page 18 restorative 5 times (Aug 3, 4, 5, 6, 8), the week of August 16-22, the resident received restorative 3 times (Aug 17, 18, 21) and the week of August 23-29, the resident received restorative 5 times (Aug 24, 26-29). The week of September 7-12, the resident received restorative 5 times (September 7-11), week of Sept 13-19, the resident received restorative 5 times (Sept 14-18), 4 times (Sept 21-24) the week of Sept 20-26, 4 times (Sept 29, 30, Oct 1, 2) the week of Sept 27 - Oct 3, 4 times (Oct 18, 21, 22, 23), the week of Oct 18-24 and 5 times (Oct 26, 27, 28, 29, 31) the week of Oct 25-31. On 11/4/15 at 10:20 AM the NA (nurse aide) #4 was interviewed. She stated that she was responsible for the restorative nursing program for Resident #21. She was aware that Resident #21 had an order to received restorative six times per. She indicated that she worked Monday to Friday to provide the restorative nursing program and another NA worked during the weekends to provide restorative nursing and to do the weights. She acknowledged that Resident #21 was not provided restorative six times per week because she was pulled to work on the floor most of the time. She added that today she was pulled to work on the floor as a nurse aide and it was hard for her to provide restorative nursing as well. On 11/4/15 at 2:40 PM, Administrative staff #2 was interviewed. She stated that she was the restorative nurse and was responsible for the restorative nursing program. She indicated that she was aware that Resident #21 had an order for restorative nursing program 6 times per week. She confirmed that Resident #21 was not	F 318	it is required by the provisions of federal and state law.	

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F 318	Continued From page 19 consistently provided the restorative nursing program 6 times per week as ordered due to restorative aide was pulled to work on the floor as nurse aide most of the time.	F 318		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		12/2/15

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 3 (unit 2 - cart 1 & 2 and unit 1 cart) of 3 medication carts and 1 (unit 2) of 2 medication room refrigerators. 1. On 11/4/15 at 11:05 AM, medication cart #2 on unit 2 was observed with Nurse #3. A bottle of Vitamin D was observed with an expiration date of 8/15. On 11/4/15 at 11:08 AM, Nurse #3 was interviewed and she agreed that the bottle of Vitamin D was already expired and stated that she would discard it. She also stated that 11-7 shift nurses were responsible for checking the medication cart for expired medications. On 11/4/15 at 3:50 PM, administrative staff #1 was interviewed. She stated that 11-7 nurses were responsible for checking the medication carts 3 times a week. She indicated that the nurse might have missed the expired Vitamin D bottle. 2. On 11/4/15 at 11:05 AM, medication cart #2 on unit 2 was observed with Nurse #3. Two opened/used bottles of Prostat (protein supplement) were observed with no date of opening. The instruction on the bottle read "discard 3 months after opening." On 11/4/15 at 11:10 AM, Nurse #3 was	F 431	F 431 Deficiency corrected 1. Corrective action has been accomplished for the alleged deficient practice in regards to dating and labeling and expired medications. The Unit Coordinator disposed of expired medications on 11/04/2015. 2. Current resident□s medication has the potential to be affected the same deficient practice. The Director of Nursing and/or Unit coordinator audited current resident medication and over the counter medication beginning on 11/05/2015, to identify medications that have expired and/or not dated when opened. Medications identified were disposed per facility policy. On 11/18/2015, the facility pharmacy representative provided in-service education for current licensed staff regarding medication maintenance pertaining to dating, labeling and expiration of medications. 3.Measures put into place to ensure the alleged deficient practice does not recur include: On 11/18/2015, the facility pharmacy representative provided in-service education for current licensed staff regarding medication maintenance pertaining to dating, labeling and expiration of medications. The licensed nurses on the 11-7 shift will audit	

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F 431	Continued From page 21 interviewed. She stated that the prostat should have been dated when opened. She also stated that 11-7 shift nurses were responsible for checking the medication carts. On 11/4/15 at 3:50 PM, administrative staff #1 was interviewed. She stated that 11-7 nurses were responsible for checking the medication carts 3 times a week. She was not sure if the nurses were checking multi dose medications for date when the medication was opened. 3. On 11/4/15 at 11:10 AM, medication cart #1 on unit 2 was observed with Nurse #3. There was a used advair discus (use to treat asthma and chronic obstructive pulmonary disease) 250/50 was that undated. The instruction on the box read " discard 30 days after removing from the foil pouch. " On 11/4/15 at 11:12 AM, Nurse #3 was interviewed. She stated that the advair should have been dated when removed from the foil pouch. She also stated that 11-7 shift nurses were responsible for checking the medication carts. On 11/4/15 at 3:50 PM, administrative staff #1 was interviewed. She stated that 11-7 nurses were responsible for checking the medication carts 3 times a week. She was not sure if the nurses were checking multi dose medications for date when the medication was opened. 4. On 11/4/15 at 11:20 AM, the refrigerator on unit 2 medication room was observed. There was an opened Purified Protein derivatives (PPD) observed with an open date of 7/2/15.	F 431	medication carts and over the counter medications at least 3 times a week to assure medications are dated and labeled and disposed of when expired, according to facility policy. The Director of Nursing and/or the Unit coordinator will audit medication carts and over the counter medications at least 5 times a week for four weeks and then 3 times a week ongoing to assure medications are dated/labeled and disposed of when expired according to facility policy. 4. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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On 11/4/15 at 11:23 AM, Nurse #3 was interviewed. She stated that the PPD was good for 30 days after opening and she agreed the PPD was expired and she stated that she would discard it.

On 11/4/15 at 3:50 PM, administrative staff #1 was interviewed. She stated that 11-7 nurses were responsible for checking the medication carts 3 times a week but she did not indicate that the checking included the medication room refrigerator.

5. On 11/4/15 at 2:20 PM the 100 hall medication cart was observed with Nurse #1. On the cart the following items were observed:
Aspirin 325 mg (milligrams) with an expiration date of 10/15.
Lantus insulin dated as having been opened 10/2/15 and dated as to be discarded by 10/29/15. According to the manufacturer's instructions Lantus insulin vials may be kept unrefrigerated for 28 days and then must be discarded.
Lidocaine 1 % that had been used but did not have the date of first use on it. According to Centers for Disease Control guidelines "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial".

Nurse #1 acknowledged the Aspirin should have been discarded by the end of October as it had already expired and that the Lantus insulin needed to be discarded 28 days after its first use. She also indicated the Lidocaine should have

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F 431	Continued From page 23 been dated when it was first used and that there were no residents who currently had an order for Lidocaine so it should have been removed from the medication cart. Nurse #1 did not know why these medications were still on the medication cart.	F 431		
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 by: Based on record review, observation and staff	F 520	F 520 Deficiency corrected	12/2/15

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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 520	Continued From page 24 interview, the facility's Quality Assessment and Assurance (QAA) committee failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 12/4/14 in order to achieve and sustain compliance in the areas of Informed of services/charges/Resident Rights (F156), range of motion (F318) and proper labeling of drugs and biological (F431). These deficiencies were cited again on the current recertification survey of 11/4/15. The findings included: This tag is cross referenced to: F156 - Informed of services/charges/Resident's rights - Based on record review and staff interview the facility failed to notify a resident of the denial of payment for Medicare services and appeal rights before the end date of those services for 1 of 3 residents (Resident #34) reviewed for liability notices. During the recertification survey of 12/4/14, the facility was cited F156 for failing to post the names, addresses and telephone numbers of the state survey and certification agency, state licensure office and Medicaid fraud control unit and also failed to insert the name and toll free number of the Quality Improvement Organization on the notice of Medicare non coverage. F318 - Range of motion - Based on record review, observation and staff interview, the facility failed to consistently apply the bilateral hand splints and to provide the passive range of motion six times a week as ordered for 1 (Resident #21) of 3 sampled residents with limited range of motion.	F 520	1. Corrective action has been accomplished for the alleged deficient practice in regards to: Resident #34 received notice of Medicare change on 09/16/2015. Resident # 21 was re-evaluated by Occupational Therapy on 11/10/2015, with recommendation to continue restorative/splinting services. Resident #21 will continue Restorative services for ROM and splinting 6 x/week. The Unit Coordinator disposed of expired medications on 11/04/2015. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Business office manager will provide to resident and/or POA a Notice of coverage change at least 3 days prior to discontinuation of services, and a copy of the letter will be dated and retained in the residents financial file. Current residents receiving restorative services for ROM and splinting have the potential to be affected by the alleged deficient practice. The DON, MDS coordinator and/or Therapy manager began in-service education for restorative aides on 11/06/2015, regarding providing services as ordered and/or according to care plan. The Director of Nursing (DON), MDS coordinator and Therapy program manager audited/reviewed the residents records that have orders for restorative services for ROM and splinting, to validate that services remain necessary and/or appropriate, and residents are receiving services as ordered. The physician was	

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	345520	A. BUILDING _____ B. WING _____	11/04/2015

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F 520	Continued From page 25 During the recertification survey of 12/4/14, the facility was cited F318 for failing to apply the carrot splint and to provide the passive range of motion as ordered and care planned. F431 - Proper labeling of drugs and biological - Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 3 (unit 2 - cart 1 & 2 and unit 1 cart) of 3 medication carts and 1 (unit 2) of 2 medication room refrigerators. During the recertification survey of 12/4/14, the facility was cited F431 for failing to discard expired medications and to date multi dose medications when opened. On 10/4/15 at 3:40 PM, administrative staff #1 and #3 were interviewed for quality assessment and assurance (QAA). Administrative staff #3 indicated that he was new to the facility but he was the head of the facility's QAA committee. Administrative staff #1 indicated that the members of the committee consisted of the medical director, administrator, director of nursing, dietary manager, activity director, rehab director, environmental director, social worker, the pharmacist and the MDS nurse. The committee had met monthly. Administrative staff #1 indicated that she was aware that F156, F318 and F431 were repeat deficiencies. She revealed that she had been monitoring the liability letters daily on their stand up meetings. She stated that she was aware of one resident with a late notice. She also stated	F 520	notified regarding discrepancies identified and services were initiated as ordered. Current resident□s medication has the potential to be affected the same deficient practice. The Director of Nursing and/or Unit coordinator audited current resident medication and over the counter medication beginning on 11/06/2015, to identify medications that have expired and/or not dated when opened. Medications identified were disposed per facility policy. On 11/18/2015, the facility pharmacy representative provided in-service education for current licensed staff regarding medication maintenance pertaining to dating, labeling and expiration of medications. 3. Measures put into place to ensure the alleged deficient practice does not recur include: The Administrator, Therapy Program Manager, DON and Business office manager will review residents payor changes at least 5 times a week during morning meeting, and a letter will be provided to the resident and/or POA at least 3 days prior to discontinuation of services and/or payor source. The DON, MDS coordinator and/or Therapy manager began in-service education for restorative aides on 11/06/2015, regarding providing services as ordered and/or according to care plan. The DON and/or MDS coordinator will review the restorative grid for services rendered to at least 5 residents, 5 times a week for four weeks then 5 residents monthly for four weeks, to validate services are provided as ordered and/or	

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F 520	Continued From page 26 that she was aware that the restorative nursing program was not consistently provided as ordered due to the restorative aide was pulled to work on the floor as nurse aide. Administrative staff #1 indicated that the 11-7 shift nurses were responsible for checking the medication carts three times a week. She added that according to the monitoring sheet the 11-7 shift nurses had checked the medication carts on 11/2/15 and they might have missed the expired medications. She also stated that she didn't know if the nurses were also checking if multi dose medications had open dates on the bottle/container.	F 520	per care plan. The MDS coordinator and Therapy program manager will review/observe the residents that are receiving restorative services monthly to validate documentation and provision of services have occurred as ordered and continued services are needed and update care plan and orders as necessary. On 11/18/2015, the facility pharmacy representative provided in-service education for current licensed staff regarding medication maintenance pertaining to dating, labeling and expiration of medications. The licensed nurses on the 11-7 shift will audit medication carts and over the counter medications at least 3 times a week to assure medications are dated and labeled and disposed of when expired, according to facility policy. The Director of Nursing and/or the Unit coordinator will audit medication carts and over the counter medications at least 5 times a week for four weeks and then 3 times a week ongoing to assure medications are dated/labeled and disposed of when expired according to facility policy. The Administrator will provide in service education for the department managers beginning on 11/30/2015, regarding Quality Assurance process, monitoring and maintaining compliance. 4. The Director of Nursing and/or the Administrator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly to evaluate the effectiveness of	

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F 520	Continued From page 27	F 520	the plan and will adjust the plan based on outcomes/trends identified. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	