STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345341	A. BUILDING ______ B. WING ______	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	**100 SILVER BLUFF DRIVE CANTON, NC 28716**

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		4/7/16

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/01/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to thoroughly investigate and submit 24 hour and 5 working day reports to the North Carolina Health Care Personnel Registry (state agency) for 1 of 1 residents with bruising, swelling and a fractured hip of unknown origin. (Resident #142) The findings included: The facility undated Abuse Nursing Policy and Procedure included the following: "Reporting of Alleged Violations Involving Mistreatment, Neglect or Abuse, including Injuries of Unknown Source and Misappropriation of Resident Property:" -All injuries of unknown source will be reported immediately to the Administrator. -The Administrator or designee will immediately notify the complaint investigation intake and referral unit and the legal representative and/or interested family member of the incident and pending investigation. -"The initial report must be telephoned in or faxed within 24 hours of the incident." "Investigations of Alleged Violations: -All alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are recorded on an assessment form and reported to the Administrator or his/her designee. This assessment will be completed by the Director of Nursing (DON), the Social Service Director or their designee. -Interviews will be conducted of all pertinent parties. Signed statements will be taken from those persons who saw or heard information	F 225	This facility has always taken the reporting and investigating of all incidents of possible abuse very seriously. We have an active abuse investigation committee and know the procedure for reporting these (24 hours, 5 day reports). The Abuse Investigation and Reporting is not applicable in this situation because abuse was never suspected. Further, this was not an injury of unknown source. The resident fell from her geri-chair on 11/7/15. The nurse at the time of the incident opened an accident and incident report, notified the family, but failed to complete it or write a progress note. The nurse reported to the on-coming shift about the fall and each subsequent shift was monitoring the resident (as is evidenced by the post-fall assessment dated 11/8/15 and the skin assessment dated 11/11/15). On 11/12/15 the Fall Committee, during their routine review of all accidents and incidents, found the opened but incomplete incident report and spoke with the nurse at which time she explained what had happened. She was instructed to finish the incident report and make a late entry progress note. The following day, 11/13/15 at 6 a.m. the bruised area on the hip and thigh was found when the NA's went in to provide routine care. The NA's immediately reported it, the nurse investigated it, and as was stated to the surveyor, questioned them as to whether anything unusual had happened during their shift, which they reported it had not. The bruise was	

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pertinent to the incident. Statements will be gathered from the suspect, person making accusations, resident involved, reliable residents who may have witnessed the incident, and any other person who may have some information."
"Investigation of Injuries of Unknown Source:
-Interviews will also be conducted when a resident has an injury from an unknown source. Signed statements will be gathered from : staff who cared for the resident just prior to and just after injury; other reliable residents in the vicinity nearby area; family or visitors who may have noticed anything.
-Once an injury of unknown source has been identified, staff will observe resident and watch behavior to see if the source of injury can be identified based on the resident's behavior. (i.e. how they move their arms, walk, push a wheelchair, behave, etc.)
-The chart will be reviewed for any pertinent information which could help the investigation.
Written Report to the State Agency:
-A written report will be submitted to the Administrator and the State Agency within five working days of the incident.
-This report will contain all of the investigative information, description of the injury; signed statements from the pertinent parties; information gathered from the investigation; and the results of the investigation."

Resident #142 was admitted to the facility 05/28/14 with diagnoses which included anxiety, vascular dementia, osteoarthritis, difficulty walking and abnormal posture.

The current quarterly Minimum Data Set (MDS) dated 01/29/16 for Resident #142 assessed her with severe cognitive impairment.

reported to the Nurse Practitioner. The nurse reporting the incident to the Nurse Practitioner did not realize that she was unaware of the fall that occurred five days earlier. An X-Ray was obtained that showed a femur fracture. The Nurse Practitioner came to the DON and said she was unsure how this could have occurred without her falling. That was when the DON informed her that the resident had fallen five days earlier. The NP stated that was the cause of the fracture and bruising and was relieved we had been monitoring her for signs of further injury post-fall. Because the NP was unaware of the incident, The ADON verified that all staff and the family were aware of the fall and had been monitoring her throughout the five days post-fall. The Medical Director saw the resident on 11/17/15 and noted that although neither he nor the NP were immediately aware of the fall, the fall was the cause of the fracture and bruising and "the chronology did not change the outcome". The Fall Committee met again on 11/19/15, reviewed all information and did not see any reason to suspect abuse. The literature for femur head fractures lists the primary cause in the elderly is a fall. This injury was neither unwitnessed nor was it suspicious in location so it does not meet the criteria for citation of this tag.

Despite the fact that we do not believe a failure in our abuse investigation process has occurred, all incidents over the last 3 months were audited to ensure that there were no injuries occurring from an

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The Care Area Assessment (CAA) for Activities of Daily Living (ADL) associated with the annual 08/07/15 MDS assessment for Resident #142 noted, "Resident requires extensive to total assistance from staff for completion of all ADL tasks. She is transferred with a mechanical lift and is totally dependent for eating. She is up in chair and takes her meals in the dining room. Staff members attempt to anticipate and provide for resident's ADL needs on a routine and as needed basis."

The care plan for Resident #142 noted review dates of 11/06/15 and 02/05/16. Problem areas in the care plan for Resident #142 included the following:
-Has impaired cognitive function/dementia or impaired thought processes related to disease process, dementia.
-Resident is at risk for fall related injury secondary to use of psychotropic medications, altered cognition and poor safety awareness
-Has an ADL self care performance deficit related to dementia, limited mobility, disease process.
-Is resistive to care related to dementia. At times she resisted personal care such as showers.
-Has potential to demonstrate physical behaviors related to dementia. Poor impulse control by reaching out at times and inappropriately pinching others. Resident tends to only pinch staff members.

Review of nurses notes in the medical record of Resident #142 included the following:
11/07/15 11:30 AM I was alerted by nursing staff that resident had fallen out of chair. Resident was evaluated for injuries. Helped into her chair. Vital signs taken. Resident showed no

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unknown origin and were reported accurately. All nursing staff, CNAs and licensed nurses, were re-educated by the DON, ADON, and social services regarding un-witnessed injuries/injuries of unknown source, what constitutes a suspicious injury, and reporting and investigating abuse. See attached lesson plan and sign in sheet. All nursing staff were reminded to fill out an abuse report if abuse is suspected or if an injury of unknown source occurs. The box and forms are located at the nurses station. The nurses are aware to immediately report all bruised or other injuries and to make sure that the Nurse Practitioner or Physician's Assistant checks every fall, bruise, or other injury to ensure that nothing is missed in the investigation process. The nursing assistants were reminded of their responsibility to check every resident when they provide care, especially during their bath, and immediately report any issues. The nursing assistants were further re-educated on the use of the "stop and watch" alert that allows them to message the nurse about any changes in skin or other injuries. The licensed nurses will check the alert list on the dashboard every shift to ensure anything reported by the NA's through the "stop and watch" alert is immediately addressed. The licensed nurses will continue to complete weekly skin assessments and document these on the treatment record. The treatment nurse will make a weekly report to the Fall & Safety Committee. The Fall & Safety Committee will continue to monitor all

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signs/symptoms of distress.
11/12/15 10:39 PM-Called to resident's room by hall nursing assistant during rounds resident was combative slapping at nursing assistant, scratching and pinching. Nursing assistant noticed a skin tear to the top of the right hand. Areas cleansed with wound cleanser. Resident resting quietly in bed with eyes closed.
11/13/15 4:28 AM Labs. Drawn and specimen to lab. Resident tolerated well.
11/13/15 6:30 AM Called to resident's room by nursing assistants during morning round resident noted to have a large bruised area to her upper left inner and top thigh area. Bruise is purple in center with yellowing edges noted. Area is swollen and red around it. Left hip area is swollen as well.
11/13/15 6:32 AM Date wound identified 11/13/15. Wound location upper left thigh/hip. Wound bruise 5 inches X 6 inches. Surrounding skin edema. Periwound temp warmer than surrounding skin.
11/13/15 9:58 AM X-ray of left hip and femur due to pain and bruising.
11/13/15 1:51 PM Nurse Practitioner reviewed left hip and femur X-ray positive for fracture. New orders for Occupational Therapy to evaluate and treat for staff education related to positioning and transfers due to left hip fracture.
11/13/15 4:56 PM Ice pack to left hip/thigh for 20 minutes every four hours as needed for 48 hours. Percocet every 6 hours as needed for pain. Bed rest, do not transfer.

Review of radiology report from 11/13/15 noted, "Acute fracture of the femoral neck in the intertrochanteric region. Osteopenia is noted."

Physician/nurse practitioner progress notes in the

incident reports and all injuries weekly to ensure that the proper procedure has been followed. The DON and ADON will review all data weekly for 4 weeks, then monthly for 3 months, then quarterly to present this information to the QAPI committee until it is felt that the abuse reporting and investigating process is working effectively.

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medical record of Resident #142 included the following:
08/26/15-Total care for all ADLs. Functional quadriplegia related to advanced dementia. Geri Chair for mobility. No current skin issues. Appears comfortable.
10/26/15-Requires extensive assist with ADLs. No falls or acute illness.
11/13/15-Seen today per nurse request due to swelling and bruising of left hip area and external rotation of left leg noted this AM by staff. No recent fall or injury reported. In bed with head elevated eating her lunch. Not in any acute distress. Unable to obtain review of symptoms from resident due to dementia and delusions. Edema and mild bruising to left hip area, tender to touch or movement. No other issues reported. Left hip fracture, bed rest. Unable to verbalize level of pain. Edema to left hip and upper thigh, outward rotation of proximal femur. No recent fall or injury reported. X-ray shows osteopenia. Resident is non ambulatory. No treatment indicated due to multiple comorbidities and late stage dementia. Comfort focused care.
11/17/15-Left hip with ecchymosis, external rotation. It turns out that there was an omission in the official document and patient did have a fall the previous week that was never recorded or reported to myself or the nurse practitioner. X-ray was diagnostic. Agree with bed rest and pain control.

Review of the medical record of Resident #142 noted post incident follow-up reviews were completed after the fall on 11/07/15. These were dated 11/08/15 and 11/12/15 and indicated there were no complications related to the 11/07/15 fall.

Review of the medical record noted a skin

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assessment had been completed on 11/11/15 for Resident #142 and there were no problems identified. Nurse #3 that completed the skin assessment on 11/11/15 was interviewed on 03/10/16 at 2:47 PM and stated if there were no concerns noted during the skin assessment then nothing was documented.

On 03/09/16 at 11:00 AM the Director of Nursing (DON) stated the facility reviewed all fall and incident investigations to determine any changes to interventions to prevent falls. In a follow-up interview on 03/09/16 at 11:32 AM the incident reports for Resident #142 dated 11/07/15, 11/12/15 and 11/13/15 were provided for review. The DON stated the incident report was inclusive of all information involved in the investigation, including any staff interviews.

Review of the incident reports included the following:
11/07/15-11:30 AM I was alerted by nursing staff that resident had fallen out of chair. Resident was evaluated for injuries. Helped into her chair. Vital signs taken. Resident showed no signs/symptoms of distress. A post fall assessment dated 11/08/15 at 11:30 AM noted a fall without injury with interventions to remind the resident to call for help. There were no staff interviews attached to the investigation.
11/12/15-10:30 PM Called to resident's room by hall nursing assistant during rounds resident was combative slapping at nursing assistant, scratching and pinching. Nursing assistant noticed a skin tear to the top of the right hand. Area cleansed with wound cleanser, edges were approximated will and skin tear protocol implemented. There were no staff interviews attached to the investigation.

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11/13/15-6:22 AM Called to resident's room by nursing assistants during morning round resident noted to have a large bruised area to her upper left inner and top thigh area. Bruise is purple in center with yellowing edges noted. Area is swollen and red around it. Left hip area is swollen as well. Resident assessed for pain/discomfort routine Tylenol given per order. Resident repositioned in bed. Will notify physician. There were no staff interviews attached to the investigation.

Notation from the incident review committee noted the 11/07/15, 11/12/15 and 11/13/15 were reviewed in the 11/19/15 meeting with documentation which included:
11/19/15-Review of the 11/07/15 fall noted, "Per fall review committee: Resident has left hip/femur fracture. Occupational therapy for positioning, bed rest, routine and as needed pain medications."
11/19/15-Review of the 11/12/15 skin tear noted, "Per incident review committee: Resident combative, has fragile skin. No abuse suspected. Will monitor in Treatment Administration Record."
11/19/15-Review of the 11/13/15 "bruise" noted, "Per fall committee: Left hip/femur fracture. Occupational therapy for positioning, bed rest, routine and as needed pain medication."

On 03/09/16 at 2:53 PM the DON stated the nurse that completed the incident/accident report was responsible to complete the report and determine the cause of injury and come up with an initial plan of correction. The DON stated both she and the nurse practitioner were notified of any major injuries. The DON stated the incident report would "flag" and be accessible to management staff to review. The DON stated

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F 225	Continued From page 8 within 24 hours of an incident the responsible nurse or nurse manager was responsible to do a follow-up review to determine if anything was missed in the investigation and if there were any suspicions of abuse. The DON stated when the fall/incident committee met they reviewed the incident reports to determine if there was any missing information in the review. The DON stated what was discussed in the fall/incident meeting was included in the notations. The DON stated a 24 hour and 5 day report would be completed and submitted to the North Carolina Health Care Personnel Registry (state agency) if they suspect equipment malfunction or abuse or neglect. On 03/09/16 at 3:34 PM in a follow-up interview the DON stated that initially on 11/13/15 when the bruise was found on the hip of Resident #142 they did not know about the 11/07/15 fall because the nurse had only partially completed an incident report. The DON stated though the bruising on 11/13/15 was fresh, she felt the bruise, swelling and hip fracture were all related to the 11/07/15 fall. The DON stated she did not have any additional information related to the bruise/swelling and fracture discovered on 11/13/15 on Resident #142. The DON stated she spoke with staff that worked with Resident #142 on 11/12/15 and nothing unusual was reported. The DON stated staff interviewed were not documented and written statements were not obtained. The DON stated because Resident #142 is completely bedfast, non weight bearing and totally dependent they did not suspect abuse and did not complete a 24 hour or 5 day report. The DON stated she felt when Resident #142 slid out of the chair on 11/07/15 it caused a hairline fracture and the fracture became displaced either when staff placed Resident #142 in bed on 11/12/15 or were providing between	F 225		

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11/12/15-11/13/15.

On 03/09/16 at 4:24 PM Nurse #2 that worked with Resident #142 from 11/12/15 at 7:00 PM-11/13/15 at 7:00 AM stated she recalled the bruising that was reported in the AM on 11/13/15. Nurse #2 stated she filled out the incident report which included the circumstances. Nurse #2 stated she did not do an investigation when completing an incident report. Nurse #2 stated because of the seriousness of the injury she did report it to the oncoming nurse as well as the physician. Nurse #2 stated when the incident report was completed she assumed management staff did the investigation which included talking to staff. Nurse #2 stated she did not interview staff about the bruising, did not recall being interviewed about the injury by management staff and had not written a statement. Nurse #2 stated the post fall assessments completed 11/13/15 and 11/14/15 included a "no" to the question "was abuse indicated in relation to this incident" and was answered in the negative only because the cause of the injuries was not witnessed.

On 03/09/16 at 4:49 PM Nurse Aide (NA) #5 that worked with Resident #142 on 11/12/15 from 7:00 PM-11/13/15 at 7:00 AM stated she recalled working with Resident #142 on 11/12/15-11/13/15. NA #5 stated she was present when the skin tear happened on 11/12/15, had assisted to reposition Resident #142 during the night and was present when the bruising and swelling was found in the AM on 11/13/15. NA #5 stated she immediately reported the bruising and swelling to the nurse and the nurse asked her if anything happened. NA #5 stated other than the nurse, no one had asked her about working with Resident #142 on 11/12/15-11/13/15 and she had

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F 225	Continued From page 10 not written a statement. On 03/09/16 at 3:00 PM NA #4 that worked with Resident #142 on 11/12/15 from 7:00 PM-11/13/15 at 7:00 AM stated she assisted another NA to put Resident #142 to bed that night and did not see any bruising on her hip or thigh. NA #4 stated after 11/13/15 she was asked by management staff if she was aware of any bruising. NA #4 stated she was not asked any other questions about the events of 11/12/15-11/13/15 and had not written a statement. On 03/09/16 at 4:00 PM NA #3 stated she gave Resident #142 a shower a couple days after the 11/07/15 fall and did not see any swelling or bruising on the resident's thighs or hips. On 03/10/16 at 10:00 AM the DON provided written statements about the bruising/swelling and hip fracture involving Resident #142 on 11/13/15. The DON stated she obtained the statements from staff on 03/09/16-03/10/16. One of the statements provided was from Nurse #4 that was present on 11/07/15 when Resident #142 fell out of her chair. This statement noted that Resident #142 had been assessed 11/07/15-11/12/15 and "no injuries were noted". The DON stated although the 11/13/15 injury involving Resident #142 was unwitnessed she felt she did not have to complete the 24 hour or 5 day working report to the State Agency because she did not suspect abuse.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		4/7/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BLUFF INC	100 SILVER BLUFF DRIVE CANTON, NC 28716

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F 278	Continued From page 11 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews, the facility failed to accurately code 2 areas of the Minimum Data Set (MDS) for 1 of 16 residents (Resident #116). The findings included: Resident #116 was admitted to the facility on 01/18/16 with diagnoses which included cancer, heart failure, respiratory failure and anxiety. The admitting MDS dated 01/25/16 indicated Resident	F 278	The MDS of resident number 333268 was immediately corrected and re-transmitted. All comprehensive MDS' were audited by the DON from the last 2 months to ensure accuracy in documentation by the MDS coordinators. All nursing assistants were re-educated by the DON and ADON on proper documentation in Point of Care which is	

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F 278	Continued From page 12 #116 required extensive assistance with bed mobility, transfers, toileting, hygiene and eating. The MDS further indicated Resident #116 required 2 person assistance for eating. The MDS also indicated Resident #116 was not receiving hospice services. During an interview with Resident #116 on 03/10/16 at 9:25 AM, Resident #116 stated she was receiving hospice services from an outside agency almost weekly since being readmitted to the facility from a hospitalization. Record review revealed Resident #116 signed the contract for hospice services in the facility on 01/18/16. Review of the MDS dated 01/25/16 indicated Resident #116 had not been coded as receiving hospice services. Review of the MDS dated 01/25/16 for activities of daily living (ADL's) indicated Resident #116 required 2 person assistance for eating on one occasion during the look back period. During an interview with Nurse Aide #1 (NA #1) on 03/10/16 at 11:24 AM, NA #1 validated she entered the coding for Resident #116 which indicated she had required 2 person assistance with eating on 01/19/16. NA #1 stated she had been trying unsuccessfully to assist Resident #116 with her meal. NA #1 stated she requested the assistance of another NA to try and assist Resident #116 with her meal. NA #1 verified she had charted a 2 person assist since they both had attempted to assist Resident #116 with her meal. NA #1 further indicated that she and the other NA were not in the room at the same time assisting Resident #116 with her meal. During an interview with MDS Coordinator #1 (MDSC #1) on 03/10/16 at 11:39 AM, MDSC #1 acknowledged the coding for Hospice was incorrect and Resident #116 should have been coded as receiving Hospice services. MDSC #1	F 278	supplied for Section G of the MDS(especially in regards to feeding). Licensed nurses were re-educated on proper documentation of UDA assessments for the information that is supplied for the MDS' to ensure accuracy in information provided. See attached lesson plan and sign in sheet. The MDS Coordinators were sent to the NCDHSR MDS Training in Black Mountain on 3/22/16 & 3/23/16 presented by state MDS Instructor. This specific deficiency was reviewed in depth. All staff involved with the MDS process now understand their roles and responsibilities to ensure the accurate transmission of the MDS. The MDS Coordinators will carefully re-check all answers provided and question staff if there appears to be a discrepancy and then make any corrections prior to transmission of the MDS. The DON and ADON will randomly review at least 5% of comprehensive MDS submissions in their bi-monthly meeting to ensure accuracy. This will be done for at least 3 months or until it appears that the new training and plan has been effective. The DON and ADON will continue to randomly check the MDS' transmitted on a quarterly basis for at least 6 months to ensure that the MDS accurately reflects the resident and take this information to the QI Committee.	

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F 278	Continued From page 13 also acknowledged she had been taught not to change the ADL coding that transferred over into the MDS from the NA charting. MDSC #1 further acknowledged she thought if 2 people assisted a resident, even if it was 2 different times for the same meal, it could be coded as a 2 person assist. During an interview with the Director of Nursing (DON) on 03/10/16 at 4:15 PM, the DON acknowledged her expectations were for the MDS to be coded accurately.	F 278		
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, record review, and interviews the facility failed to place a floor matt at resident's bedside to prevent injury from falls for 1 of 4 residents observed who required floor mats (Resident #156). The Findings Included: Resident #156 was admitted to the facility on 05/01/14 with diagnoses which included abnormal posture, history of falling, dementia, generalized muscle weakness, and abnormal gait. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/18/15 indicated Resident #156	F 323	At the time of the survey, there were 14 residents with Geo Mats. All were properly used at all times except the one incident that is cited. This resident's mat was properly used the rest of the survey time (4 days). The NA stated that she knew she was supposed to pull out the mat and she was extremely remorseful. She stated that she just "panicked" and that her "mind went blank". Although this incident did not occur due to a lack of training, all nursing staff were re-educated by the DON/ADON on the proper use of	4/7/16

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F 323 Continued From page 14
was cognitively intact for daily decision making and required extensive assistance with bed mobility and transfers. The MDS also indicated Resident #156 had a history of falls.

Review of Resident #156's care plan revealed a risk for falls secondary to history of falls and generalized muscle weakness. Interventions included assistance of staff for transfers, medication review as needed, rehabilitation services as needed and fall mat at bedside.

Review of the task assignment initiated on 05/01/14 required for nurses and NAs to provide Resident #156 included the floor mat was to be placed at the side of the bed when he was in bed.

On 03/08/16 at 1:32 PM resident #156 was observed in his room in his chair that was reclined back with his legs dangling over the chair attempting to get up. Resident #156 stated " I am ready to get up and walk ". NA # 2 entered the resident's room and assisted the resident to transfer to his bed, put the bed in the low position, placed his call bell in reach and left the room. The floor mat was observed folded in half under the bed.

During continuous observation on 03/08/16 at 1:38 PM Resident #156 continued trying to get up out of bed and was observed placing his legs over the side rail trying to get out of the bed. NA # 2 came back into the room, talked with the resident, explained it was time for a rest and calmed him. NA # 2 left the room, the call bell remained in the resident's reach and the floor mat remained under the bed.

During continuous observation on 03/08/16 at

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Geo Mats and how to read the kardex and care plan to ensure anyone with a Geo Mat was properly placed at all times. No staff member did not know the process or procedure. See attached lesson plan and sign in sheet. All care plans, kardexes, and paper assignment sheets were re-checked by the MDS Coordinators to ensure that all information used to provide care was accurate especially as it pertains to the use of Geo Mats. The hall nurses will monitor every shift to ensure that Geo Mats are consistently and properly used. This monitoring will be documented on the treatment sheet. See attached copy. The nursing supervisor will complete at least 1 hall audit every week over the next month to ensure correct usage of Geo Mats. The DON and ADON will do random hall checks to ensure that mats are properly used and will monitor new documentation and use of Geo Mats monthly for at least 3 months. The DON will bring all data to the QAPI Committee for review. Monitoring will continue quarterly until the QAPI committee feels no further issues have occurred and proper practice is consistently occurring.

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F 323	Continued From page 15 1:52 PM NA# 2 returned to Resident #156's room to check on the resident. The floor mat was still under the resident's bed. NA # 2 was exiting the resident's room again and was asked why the floor mat was under the bed. NA# 2 stated the mat should be placed at the bedside when Resident #156 was in bed. NA # 2 returned back to the bedside, removed the floor mat from under the bed, and placed it at the resident's bed side. An interview on 03/10/16 at 11:25 AM with NA # 2 was conducted who was familiar with the Resident #156's care. NA # 2 stated she had transferred Resident #156 to bed and forgot to place the mat on the floor next to the bedside. NA # 2 further stated she should have placed the mat there after she first put Resident #156 to bed. NA #2 revealed Resident #156 had a history of falls, could become agitated, wiggled somewhat and attempted to get out of bed. NA #156 further revealed all interventions were listed in the computer on the Residents' task list for NAs and nurse to provide. NA# 2 explained Resident #156 was a high risk for falls and the mat was provided for the safety of the Resident to help prevent injuries. An interview with Nurse # 1 on 03/10/16 at 12:50 PM revealed Resident #156 becomes agitated at times and occasionally tries to get up out of bed. Nurse #1 further revealed Resident #156 does not know how to use the call bell and should be checked frequently. Nurse # 1 explained the safety tasks developed for Resident #156 included side rails up, floor mat at bed side and the bed in low position when he was in bed. Nurse #1 further explained all resident care tasks were in the computer for all staff providing care for residents. Nurse #1 stated any Resident	F 323		

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F 323	Continued From page 16 listed with a task for a floor mat must have it in place on the floor whenever the Resident is in bed. Nurse #1 further stated Resident #156 required a floor mat on the floor at bedside when he was in bed. An interview with the Director of Nursing (DON) on 03/10/16 at 1:41 PM acknowledged Resident #156 required a floor mat at the side of the bed when the resident was in bed. The DON reported staff should follow the plan of care and place a floor mat at the bedside when the Resident #156 was in bed. The DON explained the task for a floor mat for Resident #156 was in the computer under the tasks for this resident which the staff were supposed to follow. The DON further stated when a floor matt was the intervention, it should be placed at the bedside while residents were in the bed.	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 observations and staff interviews the facility failed to properly store food and clean bins housing dried food products in the facility kitchen.	F 371	Refrigerated and frozen products as cited (milk, sour cream, milkshakes, okra, grated cheese, beef patties, and dinner	4/1/16

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The findings included:

1. During the initial tour of the facility kitchen on 03/07/16 from 9:05 AM-10:00 AM the following concerns were identified:
a. An opened, one gallon container of 2% milk was stored on shelving in the reach in refrigerator. The manufacturer expiration date on the container of milk was 02/27/16. The kitchen manager reported the reach in refrigerator was checked on a daily basis by staff and any outdated items were removed. The kitchen manager stated the outdated milk must have been missed by staff when the reach in refrigerator was checked.
b. Individual cartons of milkshakes were stored in three separate cardboard boxes in the reach in refrigerator. One box had approximately 21 thawed strawberry milkshakes, another had approximately 63 thawed chocolate milkshakes and a third had approximately 25 thawed strawberry milkshakes. The manufacturer label on the milkshakes noted the milkshakes were good for 14 days after thawed. There was no indication on the milkshakes or the cardboard box which contained the milkshakes to indicate when they had been thawed. The kitchen manager stated dietary staff were supposed to date the cardboard box when the milkshakes were pulled and could not explain why that had not been done.
c. Inside the walk in freezer the following was observed: A plastic bag containing grated cheese was stored open to air and the exposed grated cheese was crystallized. A plastic bag of individual dinner rolls was stored open to air with product exposed. A plastic bag housing individual beef patties was stored open to air with product

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roll dough) were immediately disposed of. A thorough inspection of all products stored in both the freezer and refrigerator was performed to ensure there were no other products affected.

Dented Cans: the cans in question and their contents were immediately disposed of and all canned foods were inspected to ensure no other cans were affected. The dented can area (where cans are kept until the food vendor can remove and replace them) has been re-located to the manager's office to ensure that dented cans will not be used until they can be removed and replaced.

Storage Bins: the storage bins were immediately cleaned and sanitized. The bins have now been relocated to the dry storage area to prevent future contamination. The bins have been added to the daily cleaning schedule.

All dietary staff have been provided in-service training as it relates to managing food rotation, procedures for proper dating and labeling, proper procedures for handling dented cans and how to properly care for food items stored in bins. Management staff will follow up with monitoring and re-training as needed. See attached lesson plan and sign in sheet.

The Food Service Director or designee will monitor daily for 30 days and then bi-weekly for 60 days. Monitoring will then continue as needed. The Food Services

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F 371	Continued From page 18 exposed. A plastic bag containing sliced okra was stored open to air and the exposed okra was crystallized. The kitchen manager stated dietary staff were supposed to seal bags prior to placing them back in the freezer. The kitchen manager could not explain why the cheese, rolls, beef patties and okra had been stored open to air. d. A five pound container of sour cream with a manufacturer best by date of 02/15/16 was stored on shelving in the walk in refrigerator. A portion of cheese was wrapped in plastic wrap and stored inside a plastic bin housing cheese products in the walk in refrigerator. The cheese was not labeled or dated. The kitchen manager stated the walk in refrigerator was checked daily by dietary staff for any outdated products and to ensure products were properly labeled and dated. The kitchen manager could not explain why the sour cream had not been removed from the walk in refrigerator or why the cheese was not labeled or dated. e. Three rolling bins containing dried product were observed stored under a food preparation table in the kitchen. The bins housed corn meal, flour and sugar. The top of each of the rolling bins (which included the lid) had a considerable build-up of dried, sticky debris covering a significant portion of the top of the container. f. A dietary aide was observed bringing two cans of mixed fruit into the food preparation area. The dietary aide stated she removed the cans from the dry storage area and was going to use them for the lunch meal. One of the cans of mixed fruit had significant dents on both the top and bottom of the can which involved the rim area. The dietary aide was observed to open the dented can and began to portion out individual servings of fruit from the can. The concern was reported to the kitchen manager and the individual servings	F 371	Director will provide a report to the QAPI Committee.	

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F 371	Continued From page 19 that had been portioned out as well as the remaining fruit content in the dented can was discarded. The kitchen manager stated dented cans were stored in a particular area in dry storage and were not to be used. The kitchen manager spoke to the dietary aide and reported the aide stated she did not notice the can was dented. 2. On 03/10/16 at 11:00 AM the three rolling bins containing dried product were again observed stored under a food preparation table in the kitchen. The bins housed corn meal, flour and sugar. The top of each of the rolling bins (which included the lid) had a considerable build-up of dried, sticky debris covering a significant portion of the top of the container. The Food Service Director (FSD) was present at the time of the observation and reported the bins were scheduled to be cleaned each Monday. The FSD stated he was not sure if the bins had been cleaned on 03/07/16 (a Monday) and noted they needed to be cleaned.	F 371		