STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		5/24/16

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

Electronically Signed | 05/11/2016

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 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

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

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

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

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and documentation, the facility failed to notify the resident and/or responsible person by certified letter that Medicare coverage was ending for two of three residents reviewed. (Resident #17 and Resident #168). The findings included: 1. Resident #17's Medicare coverage ended on 3/1/16. Review of Resident #17's Medicare non-coverage letter dated 3/1/16, read in part, "Attempts were made to contact the resident and/or family member through telephone calls, twice on 2/25/16 and once on 2/26/16. There was no answer and no voicemail." There was no evidence that a certified letter was mailed notifying Resident #17 that medicare coverage was ending. During an interview on 4/28/2016 at 1:57 PM, the Business Office Manager revealed letters were mailed but the letters were not sent by certified mail. During an interview on 4/28/2016 at 3:25 PM, the Minimum Data Set (MDS) Coordinator stated she called three times and she mailed a letter when could not get in touch with them. During an interview on 4/28/2016 at 3:29 PM, the Administrator revealed he did not know that the letter had to be mailed certified.	F 156	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F156- Resident # 17 & 168 were mailed a certified copy of the Medicare notice of non-coverage on 5/10/2016. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents/responsible parties will be notified in writing of Medicare coverage ending, by presenting the document in person and requiring a signature or via certified mail by the Social Worker. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The MDS coordinator, Financial Counselor and Social Worker have been in-serviced on 4/28/2016 by the Administrator as to the correct procedure. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for	

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F 156	Continued From page 3 2. Resident #168's Medicare coverage ended on 3/17/16. Review of Resident #168's Medicare non-coverage letter dated 3/17/16, read in part, "Attempts were made to contact the responsible person on 3/10/16 and a message was left to call the facility. On 3/11/16 at 11:00 AM Resident #168 was sent the hospital. Resident #168 was out of the facility greater than twenty four hours and therapy was to re-evaluate. On 3/14/16, according to therapy evaluations, Resident #168 did not require skilled therapy services and therapy would not be pick up the resident." There was no evidence that a certified letter was mailed notifying Resident #168 that medicare coverage was ending. During an interview on 4/28/2016 at 1:57 PM, the Business Office Manager revealed letters were mailed but the letters were not sent by certified mail. During an interview on 4/28/2016 at 3:25 PM, the Minimum Data Set (MDS) Coordinator stated she called the family and she mailed a letter when she could not get in touch with them. During an interview on 4/28/2016 at 3:29 PM, the Administrator revealed he did not know that the letter had to be mailed certified.	F 156	monitoring to assure continued compliance. The list of residents that have been issued letters of non-coverage will be reviewed and brought to the monthly QA meeting to be monitored for continued compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		5/24/16

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F 281	Continued From page 4 by: Based on observations, record review, resident and staff interviews, the facility failed to carry over a physician ' s order from the March 2016 Medication Administration Record (MAR) to the April 2016 MAR for 1 of 3 residents reviewed for weight loss (Resident #170) and 1 of 1 resident reviewed receiving inhalation therapy (Resident #68) and failed to correctly identify a resident resulting in a resident receiving the wrong medication for 1 of 1 resident who received the wrong medication (Resident #55) and failed to follow physician ' s orders to apply a splint to prevent further contractures for 1 of 1 resident reviewed for range of motion (Resident #18) The findings included: 1. Resident #170 was admitted to the facility on 1/11/16 and had a diagnosis of Pneumonia, COPD (Chronic Obstructive Pulmonary Disease) and Anorexia. The Care Area Assessment (CAA) dated 1/15/16 revealed the resident was recently admitted following hospitalization for pneumonia and COPD and was oxygen dependent. The CAA revealed the resident required set up help only with eating. Review of the physician ' s orders revealed an order dated 3/1/16 for Standard 2.0, 120 milliliters twice a day. The resident ' s Care Plan updated 3/1/16 read: " Supplement as ordered. " Review of the March 2016 Medication Administration Record (MAR) revealed the supplement was given as ordered. Review of the April 2016 MAR revealed no entry for Standard 2.0, 120 milliliters twice a day. There were no physician ' s orders to discontinue the supplement. On 4/27/16 at 3:39 PM the Director of Nursing	F 281	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #170 on 4/27/2016 the supplement was immediately placed back on the April Medication Administration Record (MAR) and was given. Resident #55 the physician was immediately notified as well as the family on 1/11/16. The resident was monitored throughout the shift for any side effects related to receiving the wrong medication and none were noted. Resident #18 on 4/28/16 she had her splint applied immediately upon discovery that the splint was not on, and three finger nails were trimmed. Resident # 68 was discharged from the facility, the nystatin order could not be restarted because the resident was discharged, however, per MD assessment prior to discharge physician noted that no rashes were present on her body. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a 100% audit on 5/2/16 of residents with supplements orders to ensure orders	

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F 281	Continued From page 5 (DON) stated in an interview that new orders were faxed to the pharmacy and they entered the new orders on the MAR for the following month. The DON stated when the upcoming month ' s MARs were received from the pharmacy, 2 nurses checked the MARs against the physician ' s orders for the past month. The DON stated the pharmacy did not put the order on the April 2016 MAR and the 2 nurses that checked the MAR missed the order. On 4/28/16 at 8:13 AM Resident #170 stated in an interview he had several bouts of pneumonia and urinary tract infections since in the facility and had lost weight. The Resident stated they were giving him a supplement but they had stopped it and stated: " I don ' t know what that ' s about. " On 4/28/16 at 10:42 AM the Unit Supervisor stated in an interview she did the second check on the April 2016 MAR for Resident #170. The Supervisor stated she would have checked the new orders back to the first of March but apparently did not see the order for the supplement. On 4/28/16 at 11:00 AM, Nurse #1 stated in an interview that she checked the April 2016 MAR for Resident #170 against the new physician ' s orders for March 2016. The Nurse stated she did not see the order for the supplement. 2. Resident #55 was admitted to the facility on 1/7/16 for rehabilitation after having a total right shoulder replacement. The resident did not have a diagnosis of a thyroid disorder. The Admission Minimum Data Set (MDS) Assessment dated 1/14/16 revealed the resident was cognitively intact, had minimal hearing difficulty and clear speech. The MDS revealed the resident was understood by others and understood others. Review of a medication error report dated 1/11/16	F 281	were on current MAR. Any order discovered to be missing from the MAR was placed on the MAR immediately. The Director of Health Services and Nurse Management performed a 100% audit on 4/29/16 of residents with orders for splints and range of motion to ensure orders were being carried out. Any identified concerns were addressed with the MD and/or a Rehab referral made. The Director of Health Services and Nurse management performed a medication audit of all new admits from 4/1/16 to present for order transcription accuracy. The Director of Health Services and Nurse management performed an audit of all new physician□s orders for transcription accuracy from 4/28/2016 forward. Any identified concerns were addressed with the MD. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 4/29/16 by the Clinical Competency Coordinator for Licensed nurses on order transcription including but not limited to supplements, splints, and new admissions. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Education began on 4/28/16 by the	

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F 281	Continued From page 6 at 6:30 AM revealed a nurse went in to give Synthroid (thyroid medication) 100 micrograms to a resident and called the resident ' s name and the resident said yes and the nurse administered the Synthroid. The report revealed the nurse realized she had given the medication to the wrong resident. A nurse ' s note dated 1/11/16 at 7:30 AM revealed Resident #55 had received medication ordered for the resident ' s roommate. The note revealed the physician ' s assistant and a family member was notified as well as the Assistant Director of Nursing. On 4/27/16 at 4:00 PM the Director of Nursing stated in an interview she spoke with Nurse #2 and went over resident identification during a medication pass with the nurse. The DON stated the physician was notified and the physician told her the medication would not hurt the resident. On 4/27/16 at 6:10 PM Nurse #2 stated in an interview she went in the resident ' s room around 5:30 AM and saw only one name on the door and there was a resident in the first bed. The Nurse stated it was dark and the curtain was pulled between the 2 beds. The Nurse stated she ask the resident in the first bed if she was (name of resident) and the resident said yes. The Nurse stated she told the resident she had her synthroid medication. The Nurse stated the resident looked a little puzzled and she asked Resident #55 if she took thyroid medication and the resident said yes. The Nurse stated the resident sat up and took the medication. The Nurse stated she later realized there was a resident in the second bed and asked that resident her name and realized she had given the Synthroid to the wrong resident. The Nurse stated she notified the physician, the responsible party and the assistant director of nursing.	F 281	Clinical Competency Coordinator for Licensed nurses on Medication administration including but not limited to the 5 rights, medication errors, order transcription, medication reconciliation at the end of each month. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Education began on 4/28/16 by the Clinical Competency Coordinator for Licensed and non-licensed nursing staff on proper splinting and following all physicians orders as well as making all nursing staff aware that it is the responsibility of the treatment nurse to ensure that the splint is applied and removed according to physicians orders. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Supplement orders will be monitored on 5 residents to include new and current orders each week for 6 weeks then 3 residents each week for 4 weeks by the Director of Health Service/Unit Managers. New admission orders and new physician□s orders to include transcription to the MAR, will be monitored Monday through Friday by the Unit Managers and week-ends by the Supervisor for 2 months. The Nurse managers will monitor the	

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F 281	Continued From page 7 3. Resident #18 was admitted to the facility on 5/5/2011 with diagnoses that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer ' s dementia. The most recent quarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 was assessed as having functional limitation in range of motion in the upper and lower extremities on both sides of the body. The resident ' s care plan dated 3/16/15 indicated the resident had decreased ROM (range of motion) related to contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 hours on and 12 hours off for positioning and joint integrity as resident will tolerate. The care plan was documented as reviewed on 4/21/16. Physician ' s orders were reviewed and revealed an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 hours on and 12 hours off, (9AM on) (9 PM off) for positioning and joint integrity. A record review of the Medication Administration Record for January through April 27, 2016 was conducted. The April MAR showed	F 281	residents with splints and ROM orders daily x 2 weeks then weekly x 4 weeks then monthly thereafter to ensure splints and ROM are being completed as ordered. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.	

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F 281	Continued From page 8	F 281		

documentation that the orthosis device was documented as applied at 9 AM and removed at 9 PM from April 1 through April 27, 2016.
On 4/26/16 at 1:09 PM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand.
On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand.
On 4/28/16 at 9:13 AM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand.
During an interview on 4/28/16 at 9:36 AM the Director of Nursing stated that she expected Resident #18 to wear the orthosis device daily.
On 4/28/16 at 9:41 AM the resident ' s nursing assistant stated that morning she was busy and did not return to put the device on the resident. She indicated it was not clear who was responsible for putting the device on the resident.
On 4/28/16 at 9:46 AM the restorative NA stated that the resident was not no longer on the restorative caseload. She indicated that nursing assistants on the hall were educated to put the device on the resident.
On 4/28/16 at 9:34 AM nurse #6 stated that the restorative NA should apply the orthosis device.

4. Resident #68 was admitted to the facility on 3/10/16 with diagnoses including Chronic Kidney Disease (Stage III), Anxiety, Dermatitis and Dementia.

Review of the Admission Minimum Data Set (MDS) Assessment dated 3/17/16 identified Resident #68 as severely cognitively impaired.

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F 281	Continued From page 9 Review of the Admitting Physician's orders dated 3/10/16 documented an order for Nystatin ointment three times a day to underneath the breast area and Kenalog cream three times a day. Review of the March 2016 Medication Administration Record revealed the Nystatin ointment was applied three times per day and the Kenalog cream was applied three times per day until it was changed to PRN (as needed) on 3/24/16. Review of the Physician's progress note dated 3/23/16 documented a diagnosis of Candida Intertrigo (a yeast infection that occurs in skin folds) and the Nystatin ointment would continue and the Kenalog cream would be changed to PRN. Review of the April 2016 Medication Administration Record revealed there was no order for Nystatin ointment. Review of the Physician's progress note dated 4/6/16 documented Resident #68 was in no acute distress, had no skin lesions, no skin wounds and no pruritus. Her skin was warm and dry with no rashes. During an interview with the Administrator on 04/25/2016 4:55PM he stated the pharmacist did identify a few charts on 4/20/16 with transcription errors and the facility was planning to in-service staff on 4/28/16 and 4/29/16, but no chart audits had been started.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		5/24/16

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F 282	Continued From page 10 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow the care plan for the application of a splint for one of one residents (#18) reviewed for range of motion. Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer ' s dementia. The most recent quarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 was assessed as having functional limitation in range of motion in the upper and lower extremities on both sides of the body. The resident ' s care plan dated 3/16/15 and last updated on 4/21/16 indicated the resident had decreased ROM (range of motion) related to contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 hours on and 12 hours off for positioning and joint integrity as resident will tolerate. Physician ' s orders were reviewed and revealed an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 hours on and 12 hours off, (9AM on) (9 PM off)	F 282	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F282- For resident #18 on 4/28/16 she had her splint applied immediately upon discovery that the splint was not on, and three finger nails were trimmed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse Management performed a 100% audit on 4/29/16 of residents with orders for splints and range of motion to ensure orders were being carried out. Any identified concerns were addressed with the MD and/or a Rehab referral made. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 4/29/16 by the Clinical Competency Coordinator for	

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F 282	Continued From page 11 for positioning and joint integrity. A record review of the Medication Administration Record for January through April 27, 2016 was conducted. The April MAR showed documentation that the orthosis device was documented as applied at 9 AM and removed at 9 PM from April 1 through April 27, 2016. On 4/26/16 at 1:09 PM resident #18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview with the restorative nursing assistant on 4/26/16 at 1:59 PM she stated that resident #18 was no longer on the restorative case load. She stated that the NA ' s on the hall were responsible for putting splints on the residents. On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM resident #18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. On 4/28/16 at 9:13 AM resident #18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview on 4/28/16 at 9:34 AM Nurse #6 stated that the restorative nursing assistant was responsible for putting the splint device on residents. In an interview with the DON on 4/28/16 at 9:36 AM she stated that she expected resident #18 to have her orthosis device on. She stated that the restorative NA was responsible for putting the device on the resident. During an interview on 4/28/16 at 9:41 AM nursing assistant #7 she stated that morning she was busy and did not return to put the device on the resident. She indicated it was not clear who was responsible for putting the device on the resident. During an interview on 4/28/16 at 9:51 AM the	F 282	Licensed nurses on order transcription including but not limited to supplements, splints, and new admissions. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Education began on 4/28/16 by the Clinical Competency Coordinator for Licensed and non-licensed nursing staff on proper splinting and following all physicians orders as well as making all nursing staff aware that it is the responsibility of the treatment nurse to ensure that the splint is applied and removed according to physicians orders. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. The Nurse managers will monitor the residents with splints and ROM orders daily x 2 weeks then weekly x 4 weeks then monthly thereafter to ensure splints and ROM are being completed as ordered. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will	

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F 282	Continued From page 12 Therapy Manager stated that after a resident is released from restorative case load the nursing department would be notified and the nursing assistant ' s on the hall would then be responsible for putting splinting device on residents.	F 282	be discussed and continue monitoring as needed to continue compliance.	
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 observations, record review, staff and family interviews, the facility failed to provide nail care for 1 of 5 dependent residents reviewed for Activities of Daily Living (Resident #18) and failed to provide a shower for 1 of 5 dependent residents reviewed for Activities of Daily Living (Resident #52). Ex.1 Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer' s dementia. The most recent quarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18	F 312	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F312- The nails of resident# 18 were immediately trimmed. Resident #52 received his shower on 4/28 on the 7-3 shift. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A 100% audit of fingernails in the facility was conducted by the Director of Health Services/Unit Managers to locate any nails that were in need of trimming on 4/28/2016. Residents identified with dirty or long nails were cleaned and trimmed	5/24/16

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F 312	Continued From page 13 was assessed as having functional limitation in range of motion in the upper and lower extremities on both sides of the body. Review of the CNA Care Intervention Record Form dated 1/29/16 listed bathing as total care with showers, hair wash and trim fingernails/toenails with bath. On 4/27/16 at 4:30 PM resident #18 was observed lying in bed. Three fingernails on her left hand were observed ¼ inch long with broke and jagged edges. On 4/28/16 at 9:36 AM resident #18 was observed lying in bed. Three fingernails on her left hand were observed ¼ inch long with broke and jagged edges. During an interview with the Director of Nursing on 4/28/16 at 9:36 AM she stated that she expected resident fingernails to be trimmed. During an interview on 4/28/16 at 9:41 AM nursing assistant #7 stated that she usually would trim her fingernails after her bath. She stated that she was busy that day and did not get to finish. Ex. 2 Resident #52 was admitted to the facility on 2/2/09 and re-admitted on 4/12/12 with diagnoses including Cerebrovascular Accident with Hemiplegia, Contractures, Aphasia, Congestive Heart Failure (CHF), Chornic Kidney Disease and History of Pressure Ulcers. . Review of the most recent quarterly Minimum Data Set Assessment dated 1/19/16 identified Resident #52 as having short and long term memory problems and severly imparierd in making daily decisions. He was totally dependent	F 312	immediately. The shower schedule was revised on 4/29/2016 to include make-up times each day so if a resident misses a shower then it can be made up on the next shift, as the resident will allow. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? All resident□s fingernails will be monitored weekly by the unit managers for 4 weeks to ensure compliance, then they will be checked on each shower day thereafter. The Senior Care Partner will conduct weekly rounds on 5 residents each week for 5 weeks to ensure that residents received their showers as indicated in the shower schedule, then on 3 residents for 3 weeks. The nursing staff in-service began on 4/28/16 by the Clinical Competency Coordinator on maintaining appropriate nail length and following the shower schedule and what to do in the event of a missed shower as well as being added to the new hire orientation process. Staff that did not attend the in-service will be educated prior to the next scheduled shift. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.	

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F 312	Continued From page 14 on two persons for bathing. Review of the Care Plan dated 4/12/12 and last updated on 2/4/16 listed the Problem: potential for skin breakdown due to diagnoses of Congestive Heart Failure, Diabetes, Atrial Fibrillation, History of ulcer to sacrum, Bedfast, Incontinent, requires assist with bed mobility, bilateral upper extremity contractures, neck contractures and poor intake. Approaches to meeting the goal of no skin breakdown by next review included, in part: shower/bed bath as scheduled. According to the shower schedule book review, Resident #52 received showers on Monday and Thursday on the 7am - 3pm shift. Observations were made over the four day survey period. Resident #52 was observed clean an dry and without odors. Resident #52 was bedfast. During an observation of incontinent care, Resident #52 was noted to have no skin breakdown on his buttocks area, but did have a healed area of previous pressure. During a family interview on 4/26/16 at 2:30pm it was stated on 4/21/16 Resident #52 did not receive his scheduled shower. The family member stated she was told the lift batteries were not working. The family member further stated on Friday 4/22/16 and Saturday 4/23/16 she had asked for Resident #52 to receive a shower. She stated it was not until Sunday before the shower was given. During an interview on 4/27/16 at 2:23pm with Nursing Assistant #4 she stated that she did not give Resident #52 a shower on 4/21/16 because	F 312	The results of the monitoring will be reviewed and brought to the monthly QA by the DHS and the findings will be discussed and any changes implemented to maintain compliance.	

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F 312	Continued From page 15	F 312		

the lift batteries were not working. She stated she thought night shift did not charge the batteries which made the lifts unuseable the next day.
During an interview with Nursing Assistant #5 on 4/27/16 at 10:30am she stated that the lifts should be charged for day shift and if they battery is dead the storage unit had " a million " batteries and you could get one from there.
During an interview with Nursing Assitant #3 on 4/28/16 at 8:42am she stated she did have Resident #52 on Friday, 4/22/16 and she had bathed him and dressed him first thing, because it takes about an hour to do his care, and then the family member told her that she wanted him showered. She stated that she had others to shower on that day and could not squeeze him in and said once a resident misses a shower day it ' s hard to get them in.
During an interview with Nursing Assistant #2 on 4/28/16 at 9am she stated that she did work with Resident #52 on Saturday 4/23/16 and the family member asked her if she could shower him since he did not get showered Thursday or Friday. She stated that she never told the family member she would not shower Resident #52 but that she would try to work him in. She stated that she could never work in him because other residents were scheduled for showers that day.
During a follow up interview with Nursing Assistant #5 on 4/27/16 at 2:28pm she stated if you get a lift to use and the battery doesn ' t work you take that battery to the charging station and remove a battery that has been charging and change it out for the dead battery. She stated there are always batteries charged up.
During an interview on 4/27/16 at 2:31pm with Nursing Assistant (NA) #6 she showed the SA where the medical supply storage room was on hall 100/200 and showed SA the battery charging

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F 312	Continued From page 16 area. She stated when the battery runs low or stops there are always batteries ready to go in this room. She stated there are two storage rooms with batteries. During an interview with Nurse #5 during an on 4/27/16 at 3:56pm she stated the as the norm, showers are only given on day shift because there just are not enough NAs on evenings to do showers. She further stated that if showers do not get done on a scheduled day then the shower usually cannot be made up on another day because other residents are scheduled. She stated Resident #52 did get a shower on day shift Sunday, 4/24/16. During an interview with the Director of Nursing on 4/28/16 at 11:17am she stated if a resident doesn't get a shower on the day shift when scheduled, then any shift should try to make up that shower. There are plenty of batteries in the facility and they are stored in the med equipment room.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		5/24/16

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F 315	Continued From page 17 Based on observation, record review and staff interviews the facility failed to prevent contamination of an indwelling urinary catheter by allowing the drainage spout to rest on the floor for 1 of 1 sampled residents with a urinary catheter (Resident #100). Resident #100 was admitted to the facility on 1/5/15 and had a diagnosis of Neurogenic Bladder. The Care Area Assessment for Indwelling Urinary Catheter dated 8/6/15 revealed the resident had a urinary catheter and would be care planned to prevent urinary tract infections (UTIs). The resident ' s Care Plan dated 8/6/15 revealed the resident used an indwelling urinary catheter related to a neurogenic bladder and was at risk for UTIs. The Quarterly Minimum Data Set (MDS) dated 1/21/16 revealed the resident was cognitively intact, required extensive assistance with activities of daily living and had an indwelling urinary catheter. On 4/25/16 at 4:05 PM Resident #100 was observed lying in bed. The urinary drainage bag was hanging on the lower part of the bed. The drainage spout was clamped but was not secured and was observed lying directly on the floor. During the observation the resident stated she had a urinary tract infection and did not feel good. On 4/25/16 at 4:52 PM the resident was observed lying in bed. The catheter spout of the urinary drainage bag was clamped but was not secured and was observed resting directly on the floor. On 4/28/16 at 1:43 PM the Infection Control Nurse stated in an interview the urinary drainage spout should not be on the floor. On 4/28/16 at 3:03 PM the Director of Nursing stated in an interview the urinary drainage spout should be secured and that being on the floor	F 315	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F315- Resident # 100 had her catheter bag replaced immediately after notification that the spout had come into contact with the floor How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A 100% audit of all catheters was done on 5/2/2016 by the Director of Health Services/Unit Managers to ensure that no catheters were found on the ground or any contaminated surfaces. Identified concerns related to catheters were corrected immediately. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The DHS/Unit Managers will make rounds to observe all catheters on two days each week for 8 weeks to ensure continued compliance. Nursing staff were in-serviced on catheters and prevention of UTIs associated with catheter contamination and the education began on 4/28/16 by the Clinical Competency Coordinator as well as being added to the new hire orientation process. Staff not attending will	

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F 315	Continued From page 18 was an infection control issue.	F 315	be educated prior to next scheduled shift. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results of the monitoring will be reviewed and brought to the monthly QA by the DHS and the findings will be discussed and any changes implemented to maintain compliance.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to apply an orthosis device for one of one residents (#18) reviewed for range of motion. Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer ' s dementia. The most recent quarterly review Minimum Data	F 318	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F318- For resident #18 on 4/28/16 she had her splint applied immediately upon discovery that the splint was not on, and three finger nails were trimmed.	5/24/16

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F 318	Continued From page 19 Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 was assessed as having functional limitation in range of motion in the upper and lower extremities on both sides of the body. The resident ' s care plan dated 3/16/15 and last updated on 4/21/16 indicated the resident had decreased ROM (range of motion) related to contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 hours on and 12 hours off for positioning and joint integrity as resident will tolerate. Physician ' s orders were reviewed and revealed an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 hours on and 12 hours off, (9AM on) (9 PM off) for positioning and joint integrity. A record review of the Medication Administration Record for January through April 27, 2016 was conducted. The April MAR showed documentation that the orthosis device was documented as applied at 9 AM and removed at 9 PM from April 1 through April 27, 2016. On 4/26/16 at 1:09 PM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview with the restorative nursing assistant on 4/26/16 at 1:59 PM she stated that when resident #18 was in the restorative program she wore an orthosis device on her left hand. She stated that the resident was no longer on the restorative case load and the NA ' s on the hall were responsible for putting splints on the residents. On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM	F 318	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse Management performed a 100% audit on 4/29/16 of residents with orders for splints and range of motion to ensure orders were being carried out. Any identified concerns were addressed with the MD and/or a Rehab referral made. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 4/29/16 by the Clinical Competency Coordinator for Licensed nurses on order transcription including but not limited to supplements, splints, and new admissions. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Education began on 4/28/16 by the Clinical Competency Coordinator for Licensed and non-licensed nursing staff on proper splinting and following all physicians orders as well as making all nursing staff aware that it is the responsibility of the treatment nurse to ensure that the splint is applied and removed according to physicians orders. Education will be added to new hire orientation and staff not completing the	

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F 318	Continued From page 20 resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview on 4/28/16 at 8:28 Am the Therapy Manger stated that when resident #18 was discharge from therapy in July 2015 she was able to tolerate the orthosis device on her left hand/ wrist. She stated that staff were educated on passive range of motion and application of the device. On 4/28/16 at 9:13 AM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview on 4/28/16 at 9:34 AM Nurse #6 stated that the restorative nursing assistant was responsible for putting the splint device on residents. In an interview with the Director of Nursing on 4/28/16 at 9:36 AM she stated that she expected resident #18 to have her orthosis device on. She stated that the restorative NA was responsible for putting the device on the resident. During an interview on 4/28/16 at 9:41 AM nursing assistant #7 stated that morning she was busy and did not return to put the device on the resident. She indicated it was not clear who was responsible for putting the device on the resident. During an interview on 4/28/16 at 1:15 PM Nurse #7 stated that he thought the restorative nursing assistant was responsible for applying the orthosis device on resident #18.	F 318	training will be educated prior to the start of the next scheduled shift. The Nurse managers will monitor the residents with splints and ROM orders daily x 2 weeks then weekly x 4 weeks then monthly thereafter to ensure splints and ROM are being completed as ordered. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325		5/24/16

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F 325	Continued From page 21 status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to administer a nutritional supplement for 1 of 3 residents reviewed for weight loss (Resident #170). The findings included: Resident #170 was admitted to the facility on 1/4/16 and had a diagnosis of Pneumonia, Chronic Respiratory Failure, COPD (Chronic Obstructive Pulmonary Disease) Urinary Retention and Anorexia. A Nutritional Screening and Assessment Form dated 1/11/16 signed by the consulting dietician noted the resident weighed 179 pounds. The assessment revealed the resident consumed 25% of his meals, was within his ideal body weight of 160-199 pounds and would continue to monitor. The Care Area Assessment (CAA) dated 1/15/16 for Nutrition revealed the resident received a NAS (no added salt) regular consistency diet and had no difficulty chewing or swallowing. The CAA revealed the resident ' s weight was 179 pounds and was at risk for weight changes related to COPD with oxygen use and pneumonia. The resident ' s Care Plan dated 1/15/16 noted the resident was at risk for weight changes related to COPD with oxygen use and pneumonia. The Care Plan directed staff to allow	F 325	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F325- For resident #170 on 4/27/2016 the supplement was immediately placed back on the April Medication Administration Record (MAR) and was given. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a 100% audit on 5/2/16 of residents with supplements orders to ensure orders were on current MAR. Any order discovered to be missing from the MAR was placed on the MAR immediately. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?	

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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 325	Continued From page 22 resident ample time to eat due to shortness of breath. A Nutritional Screening and Assessment Form dated 1/21/16 signed by the consulting dietician revealed the resident ' s current body weight was 174 pounds and was down 5 pounds since admission. The assessment revealed the resident would be offered a snack and hydration three times a day and monitored for significant changes. Review of the resident ' s weekly weight record revealed a weight of 166 on 2/15/16. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 2/29/16 revealed the resident was cognitively intact and required set up help, supervision and encouragement with eating. There was a physician ' s order dated 3/1/16 for Standard 2.0 (nutritional supplement), 120 milliliters twice a day. On 3/1/16 the resident ' s Care Plan was updated and directed staff to provide supplements as ordered and to monitor weights per policy and as ordered. Review of the Medication Administration Record (MAR) for March 2016 revealed a handwritten order for Standard 2.0, 120millilites twice a day and the MAR revealed the nutritional supplement was given as ordered. Review of the resident ' s weekly weight record revealed the following weights: 3/2/16 160 pounds. 3/9/16 167 pounds. 3/23/16 163 pounds. 3/30/16 160 pounds. Review of the MAR for April 2016 revealed no entry for Standard 2.0, 120 milliliters twice a day and there were no physician ' s orders to discontinue the nutritional supplement. Review of the resident ' s weekly weight record revealed the following weights: 4/6/16 163	F 325	Education began on 4/29/16 by the Clinical Competency Coordinator for Licensed nurses on order transcription including but not limited to supplements, splints, and new admissions. Education will be added to the new hire orientation and the staff not completing the training will be educated prior to the start of the next scheduled shift. Supplement orders will be monitored on 5 residents to include new and current orders each week for 6 weeks then 3 residents each week for 4 weeks by the Director of Health Service/Unit Managers. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.	

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	345357	A. BUILDING _____ B. WING _____	04/28/2016

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F 325	Continued From page 23 pounds. 4/13/16 161 pounds. On 4/27/16 at 2:24 PM the Dietary Supervisor stated in an interview she went around the facility and offered residents a snack at 10 AM and 2 PM. The Supervisor stated they prepared a cart and the nursing assistants offered snacks at 8 PM. The Supervisor stated she had never been able to get Resident #170 to accept a snack. On 4/27/16 at 3:39 PM the Director of Nursing (DON) stated in an interview that new orders were faxed to the pharmacy and entered on the MAR for the following month. The DON stated when the upcoming month ' s MARs were received from the pharmacy, 2 nurses checked the MARs against new orders for the resident. The DON stated the pharmacy did not put the order on the April 2016 MAR and the 2 nurses that checked the MAR missed the order. On 4/28/16 at 8:13 AM Resident #170 stated in an interview he had several bouts of pneumonia and urinary tract infections since admission to the facility and had lost weight. The Resident stated they were giving him a supplement but they had stopped it. On 4/28/16 at 10:42 AM the Unit Supervisor stated in an interview she did the second check on the April 2016 MAR for Resident #170. The Supervisor stated she would have checked the new orders back to the first of March but apparently did not see the order for the supplement. On 4/28/16 at 11:00 AM, Nurse #1 stated in an interview that she checked the April 2016 MAR for Resident #170 against the new physician ' s orders for March 2106. The Nurse stated she did not see the order for the supplement.	F 325		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		5/24/16

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F 333	Continued From page 24 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a medication was administered as ordered by the physician for 1 of 6 sampled residents (Resident #200). The findings include: Resident #200 was admitted to the facility on 4/8/16 with diagnoses including End Stage Chronic Obstructive Pulmonary Disease, Anxiety, Chronic Pain Syndrome and Hospice status. Review of the Admission Minimum Data Set (MDS) Assessment dated 4/15/16 identified Resident #200 as moderately impaired cognitively with a Brief Interview of Mental Status score of 12 and receiving Oxygen. Review of the Care Plan dated 4/20/16 listed the Problem as: Diagnosis of Chronic Obstructive Pulmonary Disease, reports of frequent shortness of breath and Oxygen ordered. The documented approaches to meeting the goal of maintaining optimal breathing and oxygen level within constraints of a terminal diagnosis included, in part, give medications as ordered. Review of the form FL2, used on admission to document the physician's orders listed the following order: Duoneb 0.5milligrams - 3 milligrams - 3 milliliters inhalation every 4 hours (Duoneb is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs).	F 333	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F333-For resident # 200 the Duoneb order was clarified on 4/25/2016 to read every 4 hours and was given around the clock every four hours. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a medication audit of all new admissions from 4/1/16 to present for order transcription accuracy. The Director of Health Services and Nurse management performed an audit of all new physician□s orders for transcription accuracy from 4/28/2016 forward. Any identified concerns were addressed with the MD. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 4/28/16 by the	

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F 333	Continued From page 25 Review of the Medication Administration Record dated 4/8/16 documented an order for Duoneb 0.5milligrams - 3 milligrams - 3 milliliters inhalation every 4 hours. Futher review revealed the medication had been signed as given 6 times since admission. The resident had been residing in the facility 17 days (4/8/16 through 4/25/16) and per order was to have received 102 doses. During a facility tour on 4/25/16 at 3:22PM Resident #200 was observed to be lying in her bed with the head of the bed up 45 degrees. She was observed to be sweating and had grimacing on her face. The State surveyor asked how she was doing and she replied she was having trouble breathing and wished she could have her Duoneb. She had Oxygen on at 2.5liters via nasal cannula. The State surveyor left the room to enquire from the nurse regarding Duoneb. During an interview with Nurse #4 on 04/25/2016 3:26PM she stated the resident had not asked for any PRN (as needed) meds except for Tylenol for a fever. Otherwise she had not received any PRN meds. When asked about the Duoneb 0.5 inhaler every four hours order Nurse #4 stated "that is PRN". Nurse #4 was shown the Medication Administration Record for April 2016 and asked if the order read "PRN?" The MAR revealed the order did not read PRN. During an interview with Nurse #5 on 4/25/16 at 3:30PM, who had entered the conversation to clarify the medication order, she stated the order seemed a bit confusing; however, Resident #200 did have an order for Morphine to help with her shortness of breath.	F 333	Clinical Competency Coordinator for Licensed nurses on Medication administration including but not limited to the 5 rights, medication errors, order transcription, medication reconciliation at the end of each month. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. New admission orders and new physician□s orders to include transcription to the MAR, will be monitored Monday through Friday by the Unit Managers and week-ends by the Registered Nurse for 8 weeks. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed, and changes implemented to maintain compliance.	

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F 333	Continued From page 26 During an interview with the Director of Nursing (DON) on 04/25/2016 3:43PM she stated that MDS Coordinator took off the admitting orders on 4/8/16. During an interview with the MDS Coordiantor on 04/25/2016 3:43:50 PM she stated she did not call and clarify the medication order as to if it was every four hours or every four hours (PRN) as needed. During a follow up interview with the DON on 04/25/2016 3:44PM she stated she would re-write the order with the number of times to give the medication and do a medication error form. She stated it was her expectation that medications be given as ordered. During an interview with the Administrator on 04/25/2016 4:55PM he stated the pharmacist did identify a few charts on 4/20/16 with transcription errors and the facility was planning to in-service staff on 4/28/16 and 4/29/16, but no chart audits had been started. He stated Resident #200s chart had most likely not been reviewed by the Pharmacist since admission. During an interview with the Physician's Assistant on 04/27/2016 10:15AM she stated that she did not believe there was any negative outcome for Resident #200 by not receiving the Duoneb every four hours.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		5/24/16

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F 425	Continued From page 27 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist interviews the pharmacy failed to add a new order for a supplement on the April 2016 Medication Administration Record for 1 of 6 residents whose medications were reviewed (Resident #170). The findings included: Resident #170 was admitted to the facility on 1/11/16 with a diagnosis of Pneumonia and Chronic Obstructive Pulmonary Disease (COPD). Review of the resident ' s medical record revealed the resident had experienced weight loss since admission to the facility and on 3/1/16 there was a physician ' s order for Standard 2.0 (nutritional supplement), 120 milliliters twice a day. The entry was observed to be hand written on the March 2016 Medication Administration Record (MAR) and initialed as given twice a day. Review of the April 2016 MAR revealed no entry	F 425	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F425- For resident #170 on 4/27/2016 the supplement was immediately placed back on the April Medication Administration Record (MAR) and was given. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a 100% audit on 5/2/16 of residents with	

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F 425	Continued From page 28 for Standard 2.0 to be given. The Director of Nursing (DON) stated in an interview on 4/27/16 at 3:39 PM the pharmacy did not enter the supplement on the April 2016 MAR or the monthly physician ' s orders and when the nurses checked the April MARs at the end of March they missed it as well. On 4/28/16 at 10:28 AM Pharmacist #1 stated in an interview their pharmacy entered new orders for medications and their medical records department entered orders for supplements. The Pharmacist stated the order sheet faxed to the pharmacy on 3/1/16 for Resident #170 had an order following the Standard 2.0 for a controlled substance. The Pharmacist stated the order sheet was marked control and did not get sent to medical records for them to enter the supplement into the system for the April 2016 MAR. The Pharmacist stated the order should have been sent to their medical records department where the supplement order would have been entered into the system.	F 425	supplements orders to ensure orders were on current MAR. Any order discovered to be missing from the MAR was placed on the MAR immediately What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 4/29/16 by the Clinical Competency Coordinator for Licensed nurses on order transcription including but not limited to supplements, splints, and new admissions. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift. Supplement orders will be monitored on 5 residents to include new and current orders each week for 6 weeks then 3 residents each week for 4 weeks by the Director of Health Service/Unit Managers. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.	

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F 441	Continued From page 29	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		5/24/16

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F 441	Continued From page 30	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility failed to clean a glucometer after use for 1 of 1 residents observed to receive a finger stick blood sugar (Resident #88).
The facility policy dated July 10, 2015 titled Blood Glucose Monitoring, Long-term Care under Introduction stated: " If one device (blood glucose monitor) must be used to monitor several residents, it must be cleaned and disinfected after every use to prevent carryover of blood and infectious agents. "
The facility's undated Skills Competency Checklist for blood glucose equipment cleaning read: " Clean the outside of the blood glucose meter, use a lint free cloth dampened with soapy water or isopropyl alcohol. Disinfect the meter with a bleach solution wipe. "
On 4/25/16 at 12:15 PM, Nurse #3 was observed to unlock the medication cart and remove a glucometer (device to check finger stick blood sugars), lancet and alcohol wipe from the cart. The nurse was observed to enter the room of Resident #88 and check a finger stick blood sugar on the resident. The nurse was observed to return to the medication cart and place the glucometer in the top drawer of the cart and locked the cart. The nurse was asked when she would clean the glucometer. The Nurse stated the glucometers were cleaned on night shift with alcohol and normal saline. The Nurse stated if there was blood on the glucometer she would wipe it off but did not clean the glucometer between residents. The Nurse stated she received training on cleaning the glucometer in orientation and was trained as stated in her

What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?

The nurse in question cleaned the glucometer according to policy immediately after the state surveyor walked away and went back into the conference room.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Education began on 4/29/16 by the CCC for Licensed nurses on how and when to clean the glucometer. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled shift.

All license nurses will perform a competency skills checklist on the correct cleaning of a glucometer prior to the start of the next scheduled shift.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

The DHS or Unit Manager will observe

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F 441	Continued From page 31 interview. On 4/25/16 at 12:25 PM the Director of Nursing (DON) stated in an interview the nurses were supposed to clean the glucometer after each use with alcohol and bleach wipes. On 4/25/16 at 12:35 PM, Nurse #3 stated in an interview she got nervous and her answer should have been to clean the glucometer with bleach wipes after each use. The Nurse stated she did not clean the glucometer after checking a finger stick blood sugar on Resident #88 while being observed but had now cleaned the glucometer. On 4/25/16 12:50 PM the Staff Development Coordinator who was also the Infection Control Nurse stated in an interview the nurses were trained in orientation to clean the glucometer with alcohol, then bleach and let dry between each use. On 4/27/16 at 4:07 PM the DON stated in an interview that Nurse #3 should have cleaned the glucometer before and after using the glucometer.	F 441	and document on 3 nurses each week for 4 weeks, then 2 nurses each week for 3 weeks to ensure that the proper procedure for glucometer cleaning is adhered to. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and changes implemented to maintain compliance.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		5/24/16

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F 514	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on document review, observations and staff interviews the facility failed to ensure medical records were not falsified to make it appear as if a hand/wrist orthosis device was on one of one sampled residents (#18) reviewed for range of motion. Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer ' s dementia. The most recent quarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 was assessed as having functional limitation in range of motion in the upper and lower extremities on both sides of the body. The resident ' s care plan dated 3/16/15 and last updated on 4/21/16 indicated the resident had decreased ROM (range of motion) related to contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 hours on and 12 hours off for positioning and joint integrity as resident will tolerate. Physician ' s orders were reviewed and revealed an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 hours on and 12 hours off, (9AM on) (9 PM off) for positioning and joint integrity. A record review of the Medication Administration Record (MAR) for January through April 27, 2016	F 514	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? For resident #18 on 4/28/16 the order was clarified/revised to read splint on 6 hours each day as tolerated by the resident. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Director of Health Services and Nurse Management performed a 100% audit of Medication Administration Records for residents receiving splinting on 5/3/2016. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? All residents receiving splinting will be monitored daily for two weeks then three times a week for three weeks, then once a week for three weeks to ensure that they are documented appropriately by the DHS/Unit Managers. Education began on 4/29/16 by the CCC for Licensed nurses on signing MAR/TAR after service or treatment is completed. Education will be added to new hire orientation and staff not completing the training will be educated prior to the start of the next scheduled	

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PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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F 514	Continued From page 33 was conducted. The April MAR showed documentation that the orthosis device was documented as applied at 9 AM and removed at 9 PM from April 25 through April 27, 2016. On 4/26/16 at 1:09 PM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview with the restorative nursing assistant on 4/26/16 at 1:59 PM she stated that resident #18 was no longer on the restorative case load. She stated that the NA ' s on the hall were responsible for putting splints on the residents. On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. On 4/28/16 at 9:13 AM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview on 4/28/16 at 9:34 AM Nurse #6 stated that the restorative nursing assistant was responsible for putting the splint device on residents. During an interview on 4/28/16 at 1:15 PM Nurse #7 stated that he could not remember when he saw the splint during his shift but he signed the MAR that the splint was on the resident.	F 514	shift. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.	