STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 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.	F 225		5/24/16

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

Electronically Signed | 05/24/2016

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 record review and resident and staff interviews the facility failed to immediately notify the administrator or Director of Nursing (DON) of an allegation of abuse for 1 of 3 residents sampled for abuse (Resident #237). The findings included: Resident #237 was admitted to the facility on 04/15/16 with diagnoses that included fracture of vertebra, history of falls, atrial fibrillation, long term use of anticoagulant, diabetes mellitus, and hyperlipidemia. Review of the comprehensive admission minimum data set (MDS) dated 04/22/16 indicated that Resident #237 was cognitively intact and required one person limited assistance with bed mobility, transfers, toileting, and personal hygiene. The MDS further revealed that Resident #237 required extensive assistance of one staff member with dressing and had no impairment to bilateral upper or lower extremities Review of a physician order dated 04/15/16 read Coumadin (medication used to thin the blood) 2 milligrams (mg) by mouth every night. Review of a physician order dated 04/15/16 read to draw a prothrombin time (PT) and international normalized ratio (INR) (used to evaluate how quickly the blood clots) every Monday. Review of a care plan dated 04/18/16 stated that Resident #237 was on an anticoagulant with risk for toxicity and abnormal bleeding. The goal of stated care plan stated Resident #237 was to be free from discomfort or adverse reactions related to anticoagulant use through the next review date. The intervention included draw labs as ordered and report abnormal labs to the physician. Interview with Resident #237 on 04/25/16 at 2:54 PM revealed that at 4:30 AM a laboratory	F 225	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F225 INVESTIGATE/REPORT ALLEGATION/INDIVIDUALS. Corrective Action: Resident #237. Resident #237 was physically assessed. No injuries, or marks or bruises were noted at that time. Solstas Laboratory was contacted immediately. Lab Technician was not allowed to return to facility. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All staff were interviewed on 5/20/2016 by Pam Keiser SW and asked if they were aware of any type of Abuse or suspected abuse that had or has occurred /transpired in the facility that has not been reported. After all staff were interviewed, no new allegations of abuse or suspected abuse were reported. Phlebotomists were also in-serviced about reporting abuse and who to report to. All alert and oriented residents were also interviewed to see if anyone else felt they had experienced	

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F 225	Continued From page 2 employee came into her room to draw her blood. Resident #237 stated that when the laboratory employee turned on the light it startled her from sleep and she asked the laboratory employee to please turn the light off and the laboratory employee ignored her request so Resident #237 again asked the laboratory employee to please turn the light off and again the laboratory employee ignored her request. Resident #237 stated that then the laboratory employee proceeded to very roughly draw blood from her right antecubital and after applying a cotton ball and piece of tape over the site slapped her antecubital area as if "slapping on a Band-Aid." Resident #237 stated she was crying because when the laboratory employee turned on the light it startled her and caused her to have a back spasm and then the behavior and the actions of the laboratory employee added to her stress. Resident #237 stated she was afraid of this laboratory employee and did not want her coming back into her room. Resident #237 stated she had reported the incident to her nurse. Interview with Nurse #3 on 4/26/16 at 4:21 PM revealed that on 04/25/16 at 8:30 AM Resident #237 stated to her that she wanted someone else to draw her blood. Resident #237 stated to Nurse #3 that the laboratory employee that drew her blood that morning was really rough while drawing her blood and then slapped the middle of her arm "as if slapping on a Band-Aid." Resident #237 also reported to Nurse #3 that the laboratory employee had told her to "stop crying" and that she was fearful of this laboratory employee and did not want her to draw her blood anymore. Nurse #3 stated that she immediately reported the incident to Supervisor #1 and Supervisor #2 as soon as she exited Resident #237's room approximately 5 to 10 minutes later.	F 225	abuse. No new allegations were reported at this time. We also informed residents who to report abuse to. Systemic Changes: Director of Nursing and /or Designee In serviced all staff (full time, part time, and PRN) to inform them that Abuse will not be tolerated and if there is any allegation of abuse it must be reported immediately to the Administrator or Director of Nursing. All staff should always report any witnessed or suspected or reported abuse promptly to the Administrator or Director of Nursing. Everyone is responsible for reporting. All reports of resident verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property shall be promptly and thoroughly investigated by facility management. It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or misappropriation of resident property, to facility management. The facility will 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	

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F 225	Continued From page 3 Interview with Supervisor #1 on 04/26/15 at 4:40 PM revealed that Nurse #3 reported to her and Supervisor #2 at approximately 9:00 AM on 04/25/16 that the laboratory employee that drew Resident #237's blood that morning was really rough and jabbed the needle in her arm and was not gentle. Supervisor #1 stated that Nurse #3 stated that Resident #237 was uncomfortable and did not want the laboratory employee back into her room. Supervisor #1 stated she could not recall if Nurse #3 stated that Resident #237 was fearful of the laboratory employee and could not recall if Nurse #3 stated that the laboratory employee had slapped the arm of Resident #237. Supervisor #1 stated she would have to ask Nurse #3 exactly what she had reported to her. Supervisor #1 stated that she had instructed Supervisor #2 to call the laboratory and tell them to not send that employee back to the facility. Supervisor #1 stated she did not follow up with Supervisor #2 and was not aware of the laboratory employee's name. Supervisor #1 stated that she did not go talk to Resident #237 and did not assess the resident. Supervisor #1 also stated she did not inform the DON of the incident. Interview with Supervisor #2 on 04/26/16 at 4:58 PM revealed that Nurse #3 had reported to her and Supervisor #1 at approximately 9:00 AM on 04/25/16 that Resident #237 did not want the laboratory employee that drew her blood on 04/25/16 back into her room, Resident #237 stated that the laboratory employee was verbally nasty to her and had slapped her in the arm "as if slapping a Band-Aid" on her arm. Supervisor #2 stated that Nurse #3 reported that Resident #237 was fearful of this laboratory employee. Supervisor #2 stated that she had reported this to the DON and then called the laboratory and told	F 225	staff to the State nurse aide registry or licensing authorities. The facility will 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 will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. Within 24 hours of the reported abuse or suspension of abuse, the Director of Nursing or Administrator must submit via fax what is called a 24 hour report. This report is sent to the Department of Health and Human Services Personnel Health Registry. The purpose of the report is to notify the agency that possible abuse or neglect has occurred and that the facility is conducting an investigation. Within 5 days a 5 day report must also be submitted. This report will include witness statements, findings and interventions. The results of all investigations will be reported to the administrator or his designated representative and to other official□s in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violations verified appropriate corrective action must be taken. This in services was completed by 5/24/2016. Phlebotomists were also	

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F 225	Continued From page 4 them the employee was no longer welcome in their facility. Supervisor #2 was unaware of the laboratory employee's name. Supervisor #2 stated that she did go and talk to Resident #237 around 5:00 PM that afternoon and apologized for the laboratory employee's behavior. Interview with the DON on 04/26/16 at 5:07 PM revealed she had not previously been made aware of the incident with Resident #237 and the laboratory employee by the facility staff. The DON confirmed that she was not made aware of the incident until the surveyor brought it to her attention. The DON stated that after hearing the information she considered this an allegation of abuse. The DON stated she would have expected Supervisor #1 and/or Supervisor #2 to immediately report this to her so she could have immediately started an investigation, notified the laboratory of the incident and filed a 24 hour working report to the state agency. In a follow up interview the DON on 04/26/16 at 6:03 PM revealed that she had started the investigation, completed and submitted the 24 hour report to the state agency and had attempted to talk to the laboratory supervisor and left multiple message with no return call. The DON was still unaware of the laboratory employee's name that drew Resident #237 blood on 04/25/16. Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she expected Supervisor #1 and Supervisor #2 to immediately report the allegation of abuse to the DON or herself so that the investigation could be started and the 24 hour report filed with the state agency.	F 225	in-serviced about reporting abuse and who to report to by 5/25/2016 by Phlebotomy Manager/Supervisor. Any staff member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quest has also incorporated this to their new hire process for phlebotomist. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by interviewing 5 staff members weekly in reference to: Has anyone reported any abuse allegations, and if so, has it been reported to the Director of Nursing or Administrator. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager,	

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F 225	Continued From page 5	F 225	Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	
F 226 SS=G	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to immediately notify the administrator or Director of Nursing (DON) of an allegation of abuse for 1 of 3 residents sampled for abuse (Resident #237) which resulted in a delay of reporting an allegation of abuse to the North Carolina Health Care Personnel Registry (state agency). Findings included: Resident #237 was admitted to the facility on 04/15/16 with diagnoses that included fracture of vertebra, history of falls, atrial fibrillation, long term use of anticoagulant, diabetes mellitus, and hyperlipidemia. Review of the comprehensive admission minimum data set (MDS) dated 04/22/16 indicated that Resident #237 was cognitively intact and required one person limited assistance with bed mobility, transfers, toileting, and personal hygiene. The MDS further revealed that Resident #237 required extensive assistance of one staff member with dressing and had no impairment to bilateral upper or lower extremities.	F 226	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES. Corrective Action: Resident #237. Resident #237 was physically assessed. No injuries, or marks or bruises were noted at that time. Quest Laboratory was contacted immediately. Lab Technician was not allowed to return to facility. Identification of other residents who may be involved with this practice:	5/24/16

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F 226	Continued From page 6 A review of the facility's abuse policy dated 07/15 read, in part, "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source and theft or misappropriation of resident property, to facility management." Review of a physician order dated 04/15/16 read, Coumadin (medication used to thin the blood) 2 milligrams (mg) by mouth every night. Review of a physician order dated 04/15/16 read, draw a prothrombin time (PT) and international normalized ratio (used to evaluate how quickly the blood clots) every Monday. Review of a care plan dated 04/18/16 stated that Resident #237 was on an anticoagulant with risk for toxicity and abnormal bleeding. The goal for the care plan problem stated Resident #237 was to be free from discomfort or adverse reactions related to anticoagulant use through the next review date. The intervention included draw labs as ordered and report abnormal labs to the physician. Review of PT laboratory report dated 04/25/16 read that the collection date and time was 04/25/16 at 1:27 AM and was received in the laboratory on 04/25/16 at 9:12 AM. Interview with Resident #237 on 04/25/16 at 2:54 PM revealed that at 4:30 AM on 04/25/16 a laboratory employee came into her room to draw her blood. Resident #237 stated that when the laboratory employee turned on the light it startled her from sleep and she asked the laboratory employee to please turn the light off and the laboratory employee ignored her request so Resident #237 again asked the laboratory employee to please turn the light off and again the laboratory employee ignored her request.	F 226	All residents have the potential to be affected by the alleged practice. All alert and oriented residents were interviewed on 5/20/2016 by Pam Keiser SW and asked if they had felt abused by staff, residents, or anyone else in the facility. We also informed residents of who to report suspected abuse to if need be. No new allegations were reported. Phlebotomists were also in-serviced about reporting abuse and who to report to. Systemic Changes: Director of Nursing and /or Designee In serviced all staff (full time, part time, and PRN) to inform them that Abuse will not be tolerated and if there is any allegation of abuse it must be reported immediately to the Administrator or Director of Nursing. All staff should always report any witnessed or suspected or reported abuse promptly to the Administrator or Director of Nursing. Everyone is responsible for reporting. The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. All reports of resident verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property shall be promptly and thoroughly investigated by facility management. It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source and theft or	

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F 226	Continued From page 7 Resident #237 stated that then the laboratory employee proceeded to very roughly draw blood from her right antecubital (the region of the arm in front of the elbow) and after applying a cotton ball and piece of tape over the site slapped her antecubital area as if "slapping on a Band-Aid." Resident #237 stated she was crying because when the laboratory employee turned on the light it startled her and caused her to have a back spasm and then the behavior and the actions of the laboratory employee added to her stress. Resident #237 stated she was afraid of this laboratory employee and did not want her coming back into her room. Resident #237 stated she had reported the incident to her nurse. Interview with Nurse #3 on 4/26/16 at 4:21 PM revealed that on 04/25/16 at 8:30 AM Resident #237 stated to her that she wanted someone else to draw her blood. Resident #237 stated to Nurse #3 that the laboratory employee that drew her blood that morning was really rough while drawing her blood and then slapped the middle of her arm "as if slapping on a Band-Aid." Resident #237 also reported to Nurse #3 that the lab employee had told her to "stop crying" and that she was fearful of this laboratory employee and did not want her to draw her blood anymore. Nurse #3 stated that she immediately reported the incident to Supervisor #1 and Supervisor #2 as soon as she exited Resident #237's room approximately 5 to 10 minutes later. Interview with Supervisor #1 on 04/26/15 at 4:40 PM revealed that Nurse #3 reported to her and Supervisor #2 at approximately 9:00 AM on 04/25/16 that the laboratory employee that drew Resident #237's blood that morning was really rough and jabbed the needle in her arm and was not gentle. Supervisor #1 stated that Nurse #3 stated that Resident #237 was uncomfortable and	F 226	misappropriation of resident property, to facility management. The facility will 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 will 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 will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. Within 24 hours of the reported abuse or suspension of abuse, the Director of Nursing or Administrator must submit via fax what is called a “24 hour” report. This report is sent to the Department of Health and Human Services Personnel Health Registry. The purpose of the report is to notify the agency that possible abuse or neglect has occurred and that the facility is conducting an investigation. Within 5 days a 5 day report must also be	

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F 226	Continued From page 8 did not want the laboratory employee back into her room. Supervisor #1 stated she could not recall if Nurse #3 stated that Resident #237 was fearful of the laboratory employee and could not recall if Nurse #3 stated that the laboratory employee had slapped the arm of Resident #237. Supervisor #1 stated she would have to ask Nurse #3 exactly what she had reported to her. Supervisor #1 stated that she had instructed Supervisor #2 to call the laboratory and tell them to not send that employee back to the facility. Supervisor #1 stated she did not follow up with Supervisor #2 and was not aware of the laboratory employee's name. Supervisor #1 stated that she did not go talk to Resident #237 and did not assess the resident. Supervisor #1 also stated she did not inform the DON of the incident. Interview with Supervisor #2 on 04/26/16 at 4:58 PM revealed that Nurse #3 had reported to her and Supervisor #1 at approximately 9:00 AM on 04/25/16 that Resident #237 did not want the laboratory employee that drew her blood on 04/25/16 back into her room, Resident #237 stated that the laboratory employee was verbally nasty to her and had slapped her in the arm "as if slapping a Band-Aid" on her arm. Supervisor #2 stated that Nurse #3 reported that Resident #237 was fearful of this laboratory employee. Supervisor #2 stated that she had reported this to the DON and then called the laboratory and told them the employee was no longer welcome in their facility. Supervisor #2 was unaware of the laboratory employee's name. Supervisor #2 stated that she did go and talk to Resident #237 around 5:00 PM that afternoon and apologized for the laboratory employee's behavior. Interview with the DON on 04/26/16 at 5:07 PM revealed she had not previously been made	F 226	submitted. This report will include witness statements, findings and interventions. The results of all investigations will be reported to the administrator or his designated representative and to other official's in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violations verified appropriate corrective action must be taken. This in service was completed by 5/24/2016. Any staff member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. Phlebotomists were also in-serviced about reporting abuse and who to report to by 5/24/2016 by Phlebotomy Managers/Supervisor. Any Phlebotomists (full time, part time, and PRN) who did not receive in-service training will not be allowed to work in the facility until the training is complete. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quest has also incorporated this to their new hire process for phlebotomist. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by interviewing 5 alert and oriented residents weekly in reference to: Have they felt	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 226	Continued From page 9 aware of the incident with Resident #237 and the laboratory employee by the facility staff. The DON confirmed that she was not made aware of the incident until the surveyor brought it to her attention. The DON stated that after hearing the information she considered this an allegation of abuse. The DON stated she would have expected Supervisor #1 and/or Supervisor #2 to immediately report this to her so she could have immediately started an investigation, notified the laboratory of the incident and filed a 24 hour working report to the state agency. In a follow up interview the DON on 04/26/16 at 6:03 PM revealed that she had started the investigation, completed and submitted the 24 hour report to the state agency and had attempted to talk to the laboratory supervisor and left multiple message with no return call. The DON was still unaware of the laboratory employee's name that drew Resident #237 blood on 04/25/16. Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she expected Supervisor #1 and Supervisor #2 to immediately report the allegation of abuse to the DON or herself so that the investigation could be started and the 24 hour report filed with the state agency timely.	F 226	abused by staff, residents, or anyone else in the facility, and if yes did they report it to staff. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		5/24/16

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F 241	Continued From page 10 Based on record review and resident and staff interviews the facility failed to treat a resident with respect and dignity when a laboratory employee spoke and acted in a manner that caused a resident to be fearful and tearful for 1 of 1 residents sampled for respect and dignity (Resident #237). The findings included: Resident #237 was admitted to the facility on 04/15/16 with diagnoses that included fracture of vertebra, history of falls, and long term use of anticoagulant. Review of the comprehensive admission minimum data set (MDS) dated 04/22/16 indicated that Resident #237 was cognitively intact and required one person limited assistance with bed mobility, transfers, toileting, and personal hygiene. The MDS further revealed that Resident #237 required extensive assistance of one staff member with dressing and had no impairment to bilateral upper or lower extremities. Interview with Resident #237 on 04/25/16 at 2:54 PM revealed that at 4:30 AM a laboratory employee came into her room to draw her blood. Resident #237 stated that when the laboratory employee turned on the light it startled her from sleep and she asked the laboratory employee to please turn the light off and the laboratory employee ignored her request so Resident #237 again asked the laboratory employee to please turn the light off and again the laboratory employee again ignored her request. Resident #237 stated that then the laboratory employee proceeded to very roughly draw blood from her right antecubital and after applying a cotton ball and piece of tape over the site slapped her antecubital area as if "slapping on a Band-Aid." Resident #237 stated she was crying because when the laboratory employee turned on the light	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F241 DIGNITY AND RESPECT OF INDIVIDUALITY. Corrective Action: Resident #237. Resident #237 was physically assessed. No injuries, or marks or bruises were noted at that time. Solstas Laboratory was contacted immediately. Lab Technician was not allowed to return to facility. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All alert and oriented residents were interviewed on 5/20/2016 by Pam Keiser SW and asked if all staff treated them with respect and dignity. No new allegations were reported. Systemic Changes: Director of Nursing and /or Designee In serviced all staff (full time, part time, and PRN) to inform them that, all staff should promote care for residents in manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This in service was	

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F 241	Continued From page 11 it startled her and caused her to have a back spasm and then the behavior and the actions of the laboratory employee added to her stress. Resident #237 stated the laboratory employee stated "stop crying." Resident #237 further stated she was afraid of this laboratory employee and did not want her coming back into her room. Resident #237 stated she had reported the incident to her nurse. Interview with Nurse #3 on 4/26/16 at 4:21 PM revealed that on 04/25/16 at 8:30 AM Resident #237 stated to her that she wanted someone else to draw her blood. Resident #237 stated to Nurse #3 that the laboratory employee that drew her blood that morning was really rough while drawing her blood and then slapped the middle of her arm "as if slapping on a Band-Aid." Resident #237 also reported to Nurse #3 that the lab employee had told her "stop crying" and that she was fearful of this laboratory employee and did not want her to draw her blood anymore. Nurse #3 stated that Resident #237 was no longer crying when she reported the incident but was visibly shaken up by the event. Nurse #3 stated that she apologized for the behavior of the laboratory employee behavior and reassured her that she would take care of the situation. Nurse #3 stated that she immediately reported the incident to Supervisor #1 and Supervisor #2 as soon as she exited Resident #237's room approximately 5 to 10 minutes later. In a follow up interview with Resident #237 on 04/26/16 at 6:35 PM revealed that the management staff had come and talked to her today about the incident and informed her that the laboratory employee would not be allowed back into the building. Resident #237 stated she "breathed a sigh of relief" when she heard this information. Resident #237 further stated that she	F 241	completed by 5/23/2016. Any staff member (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by interviewing 5 alert and oriented residents weekly in reference to: Does staff treat them with dignity and respect. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	

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F 241	Continued From page 12 was a "nervous wreck" every time her door would crack open not knowing if the laboratory employee was coming back into her room. Interview with Supervisor #2 on 04/27/16 at 10:55 AM revealed Nurse #3 had reported at approximately 9:00 AM on 04/25/16 the incident with Resident #237 and the laboratory employee. Supervisor #2 stated she went to Resident #237 and apologized for the laboratory employee's behavior, Supervisor #2 reassured Resident #237 that all employees were expected to be respectful to the residents and not talk harshly to them, this included laboratory employees. Interview with the DON on 04/27/16 at 12:00 PM revealed that she expected all employees including laboratory employees to be respectful to the residents and not speak harshly to them and certainly not make the resident fearful of them. The DON stated she had contacted the laboratory and made them aware of the incident and informed them that the employee is no longer allowed back into the facility. Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she expected all employees including laboratory employees to be respectful to the residents and not speak harshly to them and absolutely not make the resident fearful of them. The administrator confirms this laboratory employee will no longer be allowed back into the facility.	F 241		
F 242 SS=G	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		5/24/16

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F 242	Continued From page 13 about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to honor a resident request to not have her blood drawn at 4:30 AM for 1 of 1 residents sampled for choices (Resident #237) when a laboratory employee did not ask permission or explain the procedure prior to obtaining the blood from the resident. The findings included: Resident #237 was admitted to the facility on 04/15/16 with diagnoses that included fracture of vertebra, history of falls, atrial fibrillation, long term use of anticoagulant, diabetes mellitus, and hyperlipidemia. Review of the comprehensive admission minimum data set (MDS) dated 04/22/16 indicated that Resident #237 was cognitively intact and required one person limited assistance with bed mobility, transfers, toileting, and personal hygiene. The MDS further revealed that Resident #237 required extensive assistance of one staff member with dressing and had no impairment to bilateral upper or lower extremities. Review of a physician order dated 04/15/16 read, Coumadin (medication used to thin the blood) 2 milligrams (mg) by mouth every night. Review of a physician order dated 04/15/16 read, draw a prothrombin time (PT) and international normalized ratio (used to evaluate how quickly the blood clots) every Monday. Review of a care plan dated 04/18/16 stated that Resident #237 was on an anticoagulant with risk for toxicity and abnormal bleeding. The goal for the care plan problem stated Resident #237 was	F 242	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F242 SELF-DETERMINATION- RIGHT TO MAKE CHOICES Corrective Action: Resident 237. The care plan for resident #237 was immediately updated to reflect resident's choice for preferred time for getting blood drawn for laboratory. Facility In serviced all nursing staff immediately (RNs, LPNs , CNAs full time, part time, and PRN) on the updated care plan for resident #237 in reference to her preferred time for getting blood drawn for laboratory. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All alert and oriented residents were interviewed in reference to the alleged practice on 5/20/2016 by Pam Keiser SW. Residents were asked if they have a choice of when	

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F 242	Continued From page 14 to be free from discomfort or adverse reactions related to anticoagulant use through the next review date. The intervention included draw labs as ordered and report abnormal labs to the physician. Review of PT laboratory report dated 04/25/16 read that the collection date and time was 04/25/16 at 1:27 AM and was received in the laboratory on 04/25/16 at 9:12 AM. Review of a physician order dated 04/25/16 read " hold Coumadin on 04/26/16 and recheck PT on 04/27/16. Review of PT laboratory report dated 04/27/16 read that the collection date and time was 04/27/16 at 5:36 AM and was received in the laboratory on 04/27/16 at 2:03 PM. Interview with Resident #237 on 04/25/16 at 2:54 PM revealed that at 4:30 AM a laboratory employee came into her room to draw her blood. Resident #237 stated that the lab employee never asked her permission to draw her blood, the lab employee did not explain what she was going to do, and the lab employee stated "I am going to draw your blood." Resident #237 stated she was not sure why they had to wake her up at 4:30 AM to draw her blood. Resident #237 further stated each time that the laboratory employee had drawn her blood which had been 2 times, it had been during the early morning hours around 4:00 AM to 5:00 PM and she did not like not having a choice in the matter. Resident #237 also stated "I get up at 8:00 AM they could just do it then." Interview with the Unit Director on 04/27/16 at 11:20 AM revealed that the laboratory employees are in the building between 4:00 AM and 5:00 AM on Monday's and Thursday's because they travel to different buildings in the area. The Unit Director confirmed that Resident #237 blood had been obtained between 4:00 AM and 5:00 AM on	F 242	they have their labs drawn, do they have a choice when they go to sleep, do they have a choice when they want to get up, do they have a choice to have a bed bath or shower, and do have a choice to refuse treatment or lab draws. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, CNAs full time, part time, and PRN) on the fact that each resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; make choices about aspects of his or her life in the facility that are significant to the resident. Each resident has a right to choose the preferred time to getting laboratory blood work done. Education also included on what to do when a resident refuses to get a laboratory blood work done or treatment. This in service was completed by 5/24/2016. Phlebotomists were also in-serviced that the residents have the right to refuse treatment and lab draws on 5/24/2016 by Phlebotomy Managers/Supervisor. It is expected the phlebotomist will ask permission from each resident before lab draw. If the resident refuses the phlebotomist will not draw labs but will notify the nurse immediately. Each nursing staff will review the Kardex of every resident they are assigned to work with prior to start of assignment. Any nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part	

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F 242	Continued From page 15 04/25/16 but did know the exact time. The Unit Director stated that the laboratory employees are usually "here and gone by 5:00 AM." The Unit Director further stated that if a blood draw is ordered on days other than Monday's and Thursday's the facility staff is responsible for drawing the blood. Interview with the DON on 04/27/16 at 12:00 PM revealed that she expected all employees including laboratory employees to be respectful to the residents and that the laboratory employee should ask permission and explain the procedure prior to starting the blood draw. Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she expected all employees including laboratory employees to be respectful to the residents and would expect the laboratory employee to ask permission from the resident prior to starting the procedure.	F 242	time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing /interviewing alert and oriented resident in reference to choices for preferred time for getting laboratory blood work done. Audit tool will include interviewing 5 alert and oriented residents in reference to choices about their preferences when it comes to their daily plan of care and activities. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. During the daily clinical meeting (Monday-Friday) the QA team will review section F for each comprehensive assessment, which is preferences for customary, routine, and activities interview, and update the care plan. The facility will also review preferences quarterly during their care plan meeting. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program	

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F 242	Continued From page 16	F 242	reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	
F 312 SS=E	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, and staff interviews, the facility failed to provide assistance with the care of fingernails for 4 of 4 sampled residents dependent on staff for activities of daily living (Residents #36, #121, #10, and #112). The findings included: 1. Resident #36 was admitted to the facility on 04/20/15 with diagnoses which included dementia, osteoarthritis, hand contractures, joint stiffness, and depression. The annual Minimum Data Set (MDS) dated 03/14/16 indicated Resident #36 was moderately impaired for daily decisions making and required extensive assistance with all activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing. The	F 312	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Corrective Action: Resident #36, #121, #10 and #112 nails were cleaned and trimmed. Identification of other residents who may be involved with this practice:	5/24/16

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F 312	Continued From page 17 MDS further revealed Resident #36 had impaired range of motion to both sides ' upper and lower extremities. The current care plan last reviewed 03/14/16 revealed Resident #36 had a self-care performance deficit which required total assistance with ADLs. The ADL care plan goal was for the Resident #36 to improve current level of function with personal hygiene. The ADL care plan included approaches to assist Resident #36 anticipate her needs, and check nail length and trim and clean as necessary. The care plan further included staff to provide assistance with bathing, grooming and personal hygiene. A review of the annual summary nurses notes dated 03/14/16 revealed Resident #36 was moderately impaired cognitively, had no signs of rejection of care, had contractures to her hands and required extensive assistance for all ADLs including nail care. A review of the facility shower schedule indicated Resident #36 was scheduled for showers on Tuesday and Friday on the 2nd shift between 3 PM to 11 PM. A review of documentation for bath and hygiene daily report revealed Resident #36 received her shower on Tuesday 04/26/16 during the 2nd shift. A review of Resident #36's nursing assistant (NA) care task information specified she was dependent on staff for showers and grooming. The NA care task further specified grooming included nail care every shift. During an observation on 04/25/16 at 1:08 PM	F 312	All residents have the potential to be affected by the alleged practice. All resident's nails (fingers and toes) were assessed on 5/19 by Debi Flinchum RN for cleanliness to provide comfort, to meet their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. All long and dirty finger nails were trimmed and cleaned. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) that a resident who is unable to carry out activities of daily living must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Nail care of fingers and toes has to be provided to residents to provide comfort, to meet their physical and mental needs, to prevent spread of infection, to provide cleanliness and to prevent skin problems. This in service was completed by 5/24/2016. Any nursing staff member (RNs, LPNs, Medication Aides, CNAs full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using	

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F 312	Continued From page 18 Resident #36 was observed in a Geri chair in her room. The skin between the fingers of both hands were observed with crusty flaky skin and all the fingernails had rough edges and crusty skin around the fingernails. During an observation on 04/26/16 at 12:22 PM Resident #36 was in bed and the fingers and fingernails of both hands were again observed that same as the previous observation of 04/25/16. During an observation on 4/26/16 at 4:44 PM Resident #36 was in bed. The skin between the fingers of both hands were observed with crusty flaky skin and all the fingernails had rough edges and crusty skin around the fingernails. During an observation on 04/27/16 at 1:22 PM Resident #36 was in bed and stated she just had her bed bath and feels like a new woman. Resident #36 fingers and fingernails were observed and remained with crusty flaky skin between all the fingers and around all the fingernails with all the nails with rough edges. On 04/27/16 at 5:54 PM NA #1, who provided care for Resident #36 was interviewed. NA #1 stated Resident #36 required extensive assistance with all ADLs including, showers, grooming and personal hygiene. NA #1 further stated Resident #36 received her showers on Tuesday and Friday on the 2nd shift between 3 PM to 11 PM and that showers included hair washing, shaving, and nail care. She stated she did not provide nail care for Resident #36. On 04/27/16 at 2:16 PM the Director of Nursing (DON) was interviewed. The DON verified	F 312	the QA survey tool. Facility will monitor compliance by observing 5 residents requiring assistance with ADLs. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	

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Resident #36 ' s nail care was not completed. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and neat.

On 04/28/16 at 3:08 PM Nurse #3, who provided care and supervised the NAs on hall where Resident #36 resided was interviewed. Nurse #3 revealed residents received nail care during their showers or baths and as needed in between. Nurse #3 verified nail care was not provided for Resident #36. Nurse #3 explained it was her expectation that the NAs were to provide nail care for the residents and ensure the residents were clean, well groomed, and fingernails were trimmed and cleaned.

On 04/28/16 at 4:26 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was her expectation for all residents to have daily skin care, have their nails trimmed and cleaned, faces washed and dressed appropriately.

2. Resident #121 was admitted to the facility on 11/25/14 with diagnoses which included disease of the nervous system, kyphosis, and depression.

The quarterly Minimum Data Set (MDS) dated 02/26/16 revealed Resident #121 was cognitively impaired for daily decision making and required extensive assistance with all activities of daily living (ADLs) including personal hygiene and bathing. The MDS further revealed Resident #121 had impaired range of motion to the upper

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extremities, and was not coded for any behaviors or rejection of care.

The current care plan last reviewed on 02/26/16 revealed Resident #121 required assistance with the performance of ADLs due to the effects of the diagnosis of nervous disorder. The ADL care plan goal was for the Resident #121 to remain free of discomfort or complications related to the disease diagnosis. The ADL care plan included approaches to provide extensive assistance for Resident #121, to check nail length, and trim and clean as needed.

A review of the facility shower schedule indicated Resident #121 was scheduled for showers on Tuesday and Friday on the 1st shift between 7 AM to 3PM.

A review of Resident #121's nursing assistant (NA) care information sheet specified she was dependent on staff for showers and grooming.

Further review of Hospice nurses notes dated 02/01/16, and 01/15/16 indicated Resident #121 staff were to anticipate Resident #121 ' s needs and required total care from staff for all ADLs.

A review of the facility nurses notes dated 02/24/16 at 8:16 PM indicated Resident #121 staff were to anticipate Resident #121 ' s needs and required total care from staff for all ADLs.

A review of the Hospice nurses note dated 3/28/16 12:30 PM revealed Resident #121 required more assistance with transfers and ADLs due to increased weakness and was totally dependent of staff for her care.

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A review of the Hospice nurses note dated 4/7/16 at 10:09 AM revealed Resident #121 required assistance with all ADLs and was totally dependent of staff for her care.

A review of documentation for bath and hygiene revealed Resident #121 received her shower on Tuesday 04/26/16 during the 1st shift.

During an observation on 04/26/16 at 12:12 PM Resident #121 was up in her wheel chair in her room. Resident #121 ' s fingernails to both hands were observed to be approximately ½ inch long with jagged edges, old chipped pink nail polish, and a tan colored substance under all the nails.

During an observation on 04/27/16 at 1:22 PM Resident #121 was in her wheel chair and her fingernails remained long with jagged edges and tan colored substance under all the nails the same as previous observations.

On 04/27/16 at 1:49 PM NA #2, who provided care for Resident #121 was interviewed. NA #2 stated Resident #121 required extensive assistance with all ADLs including, showers, grooming and personal hygiene. NA #2 further stated Resident #121 received her showers on Tuesday 04/26/16 during the 1st shift between the hours of 7 AM and 3 PM and that showers included hair washing, shaving, and nail care. She stated she did not provide nail care for Resident #121.

On 04/27/16 at 2:16 PM the Director of Nursing (DON) was interviewed. The DON verified Resident #121 ' s nail care was not completed. The DON stated it was her expectation that nail care and shaving were completed with showers

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and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and neat.

During an observation on 04/28/16 at 8:45 AM Resident #121 ' s fingernails remained long with jagged edges and tan colored substance under all the nails the same as previous observations.

On 04/28/16 at 3:08 PM Nurse #3, who provided care and supervised the NAs on hall where Resident #121 resided was interviewed. Nurse #3 revealed residents received nail care during their showers or baths and as needed in between. Nurse #3 verified nail care was not provided for Resident #121. Nurse #3 explained it was her expectation that the NAs were to provide nail care for the residents and ensure the residents were clean, well groomed, and fingernails were trimmed and cleaned.

On 04/28/16 at 4:26 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was her expectation for all residents to have daily skin care, have their nails trimmed and cleaned, faces washed and dressed appropriately.

3. Resident #10 was admitted to the facility on 04/02/10 with diagnoses which included Alzheimer ' s, and dementia.

The current care plan last reviewed 01/11/16 revealed Resident #10 required extensive assistance with ADL due to diagnosis of dementia. The ADL care plan included approaches to assist Resident #10 to check nail

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length and trim and clean as necessary.

The quarterly Minimum Data Set (MDS) dated 04/12/16 revealed Resident #10 was severely impaired for making decisions of daily living and required extensive assistance with all activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing.

A review of the activities note dated 3/29/16 at 4:08 PM revealed Resident #10 was pleasantly confused, and received and accepted a manicure with red nail polish.

A review of the nurses ' notes on 4/12/16 revealed Resident #10 was alert and pleasant with confusion and staff were to anticipate her needs and she required total care for all Activities of Daily living (ADLs).

A review of documentation for bath and hygiene daily report revealed Resident #10 received her shower on Wednesday 04/27/16 during the 1st shift.

A review of the facility shower schedule indicated Resident #10 was scheduled for showers on Wednesday and Saturday on the 1st shift between 7 AM to 3 PM.

A review of Resident #10's nursing assistant (NA) care information sheet specified to provide grooming daily which included nail care and as needed and further revealed showers were provided on Wednesday and Saturday on the 1st shift between 7 AM to 3 PM.

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During an observation on 04/25/16 at 3:49 PM Resident #10 ' s fingernails were observed with old chipped red nail polish approximately ½ inch past the cuticle. All the fingernails on both hands were ½ inch long with jagged edges and a tan colored substance under all the fingernails.

During an observation on 04/26/16 at 9:58 AM Resident #10 ' s fingernails to both hands remained the same as yesterday ' s observation on 04/25/16.

During an observation on 04/26/16 at 4:58 PM Resident #10 ' s fingernails remained with the old chipped red polish, ½ inch long with jagged edges and tan substance under all of the nails.

During an observation on 04/27/16 at 1:14 PM Resident #10 was being transported in her wheel chair down the hall by her family representative to go to the dentist. Resident #10 ' s fingernails on both hands were observed the same as observations on the previous days 04/25/16 & 04/26/16.

On 04/27/16 at 2:16 PM the Director of Nursing (DON) was interviewed. The DON verified Resident #10 ' s nail care was not completed. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and neat.

On 04/27/16 at 3:11 PM NA #3, who provided care for Resident #10 was interviewed. NA #3 stated Resident #10 required extensive

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assistance with all ADLs including, showers, grooming and personal hygiene. NA #3 further stated Resident #10 received her showers on Wednesday and Saturday on the 1st shift between 7 AM to 3 PM and that showers included hair washing, shaving, and nail care. NA #3 revealed she provided Resident #10 her shower today (04/27/16) and did not provide her nail care.

On 04/27/16 at 5:54 PM NA #1, who provided care for Resident #10 on the 3 PM to 11 PM shift on 04/25/16 & today (04/27/16) was interviewed. NA #1 stated Resident #10 received her shower on day shift and that showers included hair washing, shaving, and nail care. NA #1 further stated that sometimes the activities department provided manicures to residents and polished their nails. NA #1 revealed she did not provide nail care for Resident #10 during her shift.

On 04/28/16 at 3:08 PM Nurse #3, who provided care and supervised the NAs on hall where Resident #10 resided was interviewed. Nurse #3 revealed residents received nail care during their showers or baths and as needed in between. Nurse #3 verified nail care was not provided for Resident #10. Nurse #3 explained it was her expectation that the NAs were to provide nail care for the residents and ensure the residents were clean, well groomed, and fingernails were trimmed and cleaned.

On 04/28/16 at 4:26 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was her expectation for all residents to have daily skin care, have their nails trimmed and cleaned, faces washed and dressed appropriately.

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4. Resident #112 was admitted to the facility on 04/19/13 with diagnoses which included non-Alzheimer ' s dementia, anxiety, and depression.

The quarterly Minimum Data Set (MDS) dated 03/29/16 indicated Resident #112 was severely impaired in cognition for daily decision making skills and was totally dependent on staff for activities of daily living (ADLs). The MDS further indicated Resident #112 had impaired range of motion to both sides ' upper and lower extremities.

The current care plan last reviewed 03/29/16 revealed Resident #112 required extensive assistance with ADLs due to diagnosis of dementia and debility. Resident #112 had a self-care performance deficit related to contractures which required total assistance with ADLs. The ADL care plan goal was for the Resident #112 to maintain current level of function with personal hygiene. The ADL care plan included approaches to assist Resident #112, anticipate her needs, and coordinate her care with the Hospice team. The care plan further included staff to provide assistance with bathing, grooming and personal hygiene.

A review of the facility shower schedule indicated Resident #112 was scheduled for showers on Tuesday and Friday on the 2nd shift between 3 PM to 11 PM. The schedule further revealed a nursing assistant (NA) from Hospice provided daily bed baths for Resident #112 which included hair washing and nail care.

A review of Resident #112's Nursing Assistant

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(NA) care task information sheet specified she was dependent on staff for showers and grooming. The NA care task sheet further specified grooming included nail care every shift.

During an observation on 04/26/16 at 11:21 AM Resident #112 was observed in her bed and all fingernails were observed approximately ¼ inch long with jagged edges and a brownish tan substance under all the fingernails.

During an observation on 04/26/16 at 4:40 PM Resident #112 was observed in bed, dressed in a clean flowered housedress. Resident #112 ' s fingernails were observed to remain the same as this morning ' s observation.

During an observation on 04/27/16 at 9:23 AM Resident #112 was observed in her chair in her room with all 10 fingernails of both hands unchanged from the observation of yesterday (04/26/16).

On 04/27/16 at 1:17 PM the NA #4, who provided Resident #112 with her bed baths, was interviewed. NA #4 revealed she provided Resident #112 with a bed bath daily Monday through Friday and the bath included washing hair 2 times a week and nail care as needed. NA #4 stated she had completed the bed bath and was awaiting assistance for completing her hair washing. During the interview NA#4 verified Resident #112 ' s fingernails were observed to have brown colored substance under the fingernails and had rough edges. NA #4 explained she did not trim or file her nails, had attempted to use a nail stick to clean under the nails and further explained she will try to do better the next time.

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F 312	Continued From page 28 On 04/27/16 at 2:16 PM the Director of Nursing (DON) was interviewed. The DON verified Resident #112 ' s nail care was not completed. The DON stated it was her expectation that nail care was completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for nail care and keeping residents clean and neat. On 04/28/16 at 3:08 PM Nurse #3, who provided care and supervised the NAs on hall where Resident #112 resided was interviewed. Nurse #3 revealed residents received nail care during their showers or baths and as needed in between. Nurse #3 verified nail care was not provided for Resident #112. Nurse #3 explained it was her expectation that the NAs were to provide nail care for the residents and ensure the residents were clean, well groomed, and fingernails were trimmed and cleaned. On 04/28/16 at 3:34 PM attempted a telephone interview with NA #5, who provided care for Resident #112. A return call was not received. On 04/28/16 at 4:26 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was her expectation for all residents to have daily skin care, have their nails trimmed and cleaned, faces washed and dressed appropriately.	F 312		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		5/24/16

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F 364	Continued From page 29 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow a recipe to preserve the nutritive value of pureed corn bread stuffing for 1 of 1 meal observations and the pureed food was served to residents. The findings included: The facility provided a recipe (not dated) for pureed corn bread stuffing instructed to use low fat milk as a "liquid" when pureeing the corn bread stuffing to reach desired consistency. On 04/28/16 observations were made of the lunch meal service. On 04/28/16 at 12:00 PM the cook was observed pureeing corn bread stuffing. The cook placed a desired amount of stuffing into a food processor, turned the machine on and while it was running the cook poured hot water into the mixture. During this observation the cook was interviewed and stated he it was his usual practice to "thin" pureed food with water to reach a mashed potato consistency. The cook reported he poured approximately 2 cups of water into the corn bread stuffing. He added that he was not concerned the water would dilute or change the food's composition. On 04/28/16 at 12:15 PM the pureed corn bread stuffing was placed on the tray line and served to residents. On 04/28/16 at 2:58 PM the Dietary Manager (DM) was interviewed and explained that water was not an appropriate liquid to use when	F 364	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected An audit tool was put into place to monitor utilization of recipes by all production staff on a daily basis. The manager also initiated practice of conducting daily stand-up meetings with dietary staff on both shifts. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. Recipes were reprinted and made available to all staff. The audit tool began on May 9, 2016 to monitor recipe use and compliance with established recipes.	

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F 364	Continued From page 30 pureeing food, unless specified in a recipe. He added that he expected cooks to follow recipes when preparing food for meal service.	F 364	Systemic Changes An in-service was conducted on May 5, 2016 by the Dietary Manager. Those who attended were all dietary production staff. The in-service topic included following standardized recipes and proper preparation of pureed foods. The meeting also addressed the initiation of daily stand-up meetings for both Dietary shifts. A follow-up in-service was conducted by Gallins Corporate Registered Dietitian on May 20, 2016. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included following standardized recipes, preparation of pureed foods, monitoring of nourishment food storage areas, maintenance of ingredient bins, monitoring of refrigerated storage temperatures and food safety storage practices. All monitoring tools/audits will be completed and findings will be reported to the weekly/monthly QA meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Dietary Manager or Consultant Dietitian for Gallins Dining and Nutrition will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. See attached monitoring tool. This	

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	345543	A. BUILDING _____ B. WING _____	C 05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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F 364	Continued From page 31	F 364	will be completed 5 days/week for four weeks and then weekly times two months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared by the Administrator in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Compliance: 5/24/2016	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to store perishable food items at safe temperatures of 41 degrees Fahrenheit (F) or below, failed to keep ingredient bins clean and failed to store food items past the use by date for 1 of 2 nourishment rooms. The findings included: 1. On 04/28/16 observations were made of the lunch meal service. Included in the observations	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	5/24/16

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F 371	Continued From page 32 at 11:27 AM the cook's refrigerator internal temperature was 52 degrees Fahrenheit. The refrigerator's external thermometer read 53 degrees Fahrenheit. Inside the refrigerator were milk, half and half cream, eggs, cream cheese and additional perishable food items. On 04/28/16 at 11:37 AM a thermometer on the outside of the refrigerator measured the internal temperature to be 54 degrees Fahrenheit. On 04/28/16 at 11:41 AM a staff member removed an oil based salad dressing from the cook's refrigerator and used the salad dressing to make a pasta salad served to residents. On 04/28/16 at 11:45 AM a staff member removed a ¼ gallon carton of half and half cream for use to make mashed potatoes. On 04/28/16 at 11:47 AM the Registered Dietitian (RD) was asked to check the temperature of the half and half cream in the ¼ gallon carton used to make mashed potatoes. The RD poured some of the half and half cream into a cup. The RD used a digital thermometer that recorded the half and half cream temperature in the cup to be 56 degrees Fahrenheit. On 04/28/16 at 11:48 AM the RD was interviewed and reported that the kitchen had a history of problems with the cook's refrigerator's temperature. She observed the refrigerator's internal thermometer that read 54 degrees Fahrenheit. On 04/28/16 at 11:49 AM the RD tested the internal temperature of cream cheese stored in the cook's frig that measured 53 degrees Fahrenheit. On 04/28/16 at 11:50 AM the morning cook was interviewed and reported that he checked the temperature of the cook's refrigerator "around 7 AM and it was about 40 degrees Fahrenheit." Review of the kitchen' temperature log for the	F 371	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective Action for Resident Affected An audit tool was put into place to monitor safe food storage practices in refrigerated storage areas, ingredient bin storage and in the nourishment room areas on a daily basis. The manager also initiated practice of completing a daily manager checklist. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. . The audit tool began on May 9, 2016 to monitor safe food storage practices. Systemic Changes On 4/25/16 the ingredient bins were immediately removed, product in the containers was discarded, the containers were thoroughly cleaned and sanitized and new product was placed in the bins; lids were labeled appropriately. Also on 4/25/16 the Manager removed the outdated items from the nourishment refrigerators. The refrigerators were thoroughly cleaned and sanitized and re-stocked. On 4/28/16 the dietary manager discarded all items that were inside the Cook's refrigerator which was above the required temperature range. The refrigeration unit was turned off until repaired by equipment repair personnel. The unit was cleaned and sanitized. When the temperature range was within	

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F 371	Continued From page 33 cook's refrigerator revealed that on 04/28/16 it was documented the internal temperature of the refrigerator to be 43 degrees Fahrenheit. On 04/28/16 at 2:58 PM the Dietary Manager (DM) was interviewed and explained that an internal temperature of a refrigerator above 41 degrees Fahrenheit should be reported immediately to either himself and/or the Maintenance Director. He stated that all items inside the refrigerator had been discarded and the salad dressing and the half and half cream should not have been used for the lunch meal. 2. During the initial tour of the kitchen on 04/25/16 at 10:12 AM, the dry ingredient bins were covered and observed to be stored under a food production table. On top of the table was a toaster oven and the table was littered with crumbs. The dry ingredient bins contained (1) food thickener, (2) panko bread crumbs and (3) sugar. Inspection of the ingredient bins revealed: - 04/25/16 at 10:19 AM the food thickener bin had brown food crumbs mixed in with the food thickener. The DM stated the brown particles in the thickener appeared to be crumbs of food. - On 04/25/16 at 10:20 AM the panko bread crumbs had dry cereal flakes mixed in the bin and the scoop was resting in the panko. Closer observation revealed the scoop's handle was resting in the panko. - On 04/25/16 at 10:21 AM the sugar bin was clean inside but the scoop's handle was resting in the sugar. During the observations the Dietary Manager was interviewed and reported that the bins should be free from debris and other food particles and the scoops should not be left in the bins. 3. Observation of the nourishment room on the 400/500 Unit on 04/25/16 at 12:15 PM revealed 1 bottle of chocolate milk that had an expiration	F 371	35-41 degrees F the unit was restocked. An in-service was conducted on April 25, 2016 by the Dietary Manager. Those who attended were all dietary staff. The in-service topic included bulk storage sanitation and maintenance of food storage areas in the nourishment rooms. Another in-service was conducted on May 5, 2016 by the Dietary Manager. Those who attended were all dietary staff. The in-service topics covered the results from the Annual Re-certification Survey which included ingredient bin storage, monitoring of refrigerated storage temperatures, maintenance of the nourishment room areas and failure to follow standardized recipes. The in-service also included the initiation of a manager's daily checklist and daily stand-up meetings for both dietary shifts. A follow-up in-service was conducted by Gallins Corporate Registered Dietitian on May 20, 2016. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included following standardized recipes, preparation of pureed foods, monitoring of nourishment food storage areas, maintenance of ingredient bins, monitoring of refrigerated storage temperatures and food safety storage practices. All monitoring tools/audits will be completed and findings will be reported to the weekly/monthly QA meeting. This information has been integrated into the standard orientation training and in the	

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F 371	Continued From page 34 date of 04/18/16, 3 cups of pudding that were dated 04/16/16 and 5 cups of pudding that were dated 04/19/16 were present in the refrigerator. An interview with the Dietary Manager on 04/25/16 at 1:15 PM revealed that he had just been into that nourishment room and had not seen the expired milk or pudding. The dietary manager stated that the pudding was good for 3 days after being placed in the refrigerator and should have been discarded along with the chocolate milk. Interview with the Administrator on 04/28/16 at 2:51 PM revealed that she would have expected the dietary manager to be routinely checking the refrigerators in the nourishments rooms and discarding expired items and rotating the other items on a daily basis.	F 371	required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Dietary Manager or Consultant Dietitian for Gallins Dining and Nutrition will monitor this issue using the "Dietary QA Audit" tool. All areas will be monitored daily. See attached monitoring tool. This will be 5 days/week for four weeks and then weekly times two months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared by the Administrator in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Date of Compliance: 5/24/2016	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		5/24/16

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F 431	Continued From page 35 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard an opened NovoLOG insulin FlexPen that was not dated when opened and an opened Levemir insulin FlexPen that was not dated when opened and were available for use in 2 of 4 medication carts and failed to ensure a medication cart was secure while the nurse was not in attendance. Findings included: 1. A review of the facility protocol regarding the storage and use of insulin dated 02/20/14 indicated insulin must have a date opened sticker	F 431	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F431 DRUG RECORDS, LABEL/STORE DRUGS AND	

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F 431	Continued From page 36 attached and the date and initials of the person opening the insulin must be written on the sticker. Resident #123 was admitted to the facility on 8/27/15 with diagnosis of diabetes mellitus. A physician's order dated 2/23/16 indicated Resident #123 was to receive NovoLOG insulin as per sliding scale before meals and at bedtime for diabetes mellitus. Review of physician's order dated 4/27/16 indicated Resident #123 was to receive NovoLOG insulin 10 units via FlexPen before meals for diabetes mellitus. On 04/28/16 at 11:15 AM Resident #123's NovoLog insulin FlexPen was observed on the 500 hall medication cart ready for use and was opened and undated. A yellow sticker was attached to the NovoLog FlexPen that stated after initial use do not refrigerate and sticker indicated insulin would expire in 28 days after opening. The NovoLOG insulin FlexPen had no date on the sticker label as to when it had been opened. A review of the Medication Administration Record (MAR) revealed Resident #123 received NovoLOG sliding scale insulin from 04/01/16 to 04/27/16 as per physician's orders as indicated by nurses' documentation on the MAR and further review revealed Resident #123 received 10 units of NovoLog insulin via FlexPen at 4:00 PM and 8:00 PM on 04/27/16 as indicated per nurses' documentation on the MAR. On 04/28/16 at 11:25 AM an interview was conducted with the Unit Director who verified that Resident #123's NovoLOG insulin FlexPen was	F 431	BIOLOGICALS Corrective Action: Medication and Treatment carts where locked and secured while the nurse was not in attendance. Any insulin that was not dated or initialed when opened was immediately discarded. Medications were immediately secured properly. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done on 5/16/2016 by Laurie Hein RN and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed, open insulin by the nurse. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must also separately lock, and have permanently affixed compartments for storage of controlled drugs. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory	

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F 431	Continued From page 37 on the 500 hallway medication cart and was opened and undated and was ready for use. The Unit Director stated the NovoLOG insulin FlexPen should have been discarded from the 500 hallway medication cart at the beginning of the 7:00 AM to 3:00 PM shift because there was no indication of when the insulin had been opened and nursing staff were unable to determine if the insulin had expired. The Unit Director stated all nurses had been in-serviced that insulin had to be dated when opened to determine the expiration date once the insulin was opened. The Unit Director immediately removed the NovoLOG insulin FlexPen from the 500 hallway medication cart. On 04/28/16 at 12:08 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that nursing staff should have dated the NovoLOG insulin FlexPen for Resident #123 when it was opened. The DON stated her expectation was that nursing staff per facility protocol would have checked that Resident #123's NovoLOG insulin FlexPen was dated when opened prior to administering the NovoLOG insulin to Resident #123. The DON stated her expectation was that nursing staff would clarify with the DON or Unit Director if they were unsure of the facility protocol for opening and dating insulin. On 04/28/16 at 2:55 PM an interview was conducted with the Administrator who stated the NovoLOG insulin FlexPen for Resident #123 should have been dated when opened. The Administrator stated staff should have verified that the insulin was dated prior to administering the NovoLOG insulin to Resident #123. On 04/28/16 at 2:55 PM an interview was	F 431	and cautionary instructions, and the expiration date when applicable. This in service was completed by 5/24/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing each medication cart, and treatment cart and any other areas that medication is stored to ensure that they are secured properly at all times. Facility will also observe all medication and treatment carts for expired, undated and not initialed, open insulin's by the nurse. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of	

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F 431	Continued From page 38 conducted with Nurse #1 who administered NovoLOG insulin 10 units via FlexPen to Resident #123 on 04/27/16 at 4:00 PM and 8:00 PM. Nurse #1 stated she had not checked Resident #123's NovoLOG insulin FlexPen for an opened date prior to administering the insulin to Resident #123 on 04/27/16. Nurse #1 stated insulin was required to be dated when opened to determine when it would expire and it was the responsibility of the nurse administering insulin to verify that insulin had an open date. Nurse #1 stated without an opened date she was unable to determine if Resident #123's NovoLOG insulin FlexPen had expired prior to administering the insulin on 04/27/16. 2. A review of facility protocol regarding the storage and use of insulin dated 02/20/14 indicated insulin must have a date opened sticker attached and the date and initials of the person opening the insulin must be written on the sticker. Resident #242 was admitted to the facility on 04/18/16 with diagnosis of diabetes mellitus. A physician's order dated 04/27/16 indicated Resident #242 was to receive Levemir insulin FlexPen 10 units in the morning for diabetes mellitus. On 04/28/16 at 11:40 AM Resident #242's Levemir insulin FlexPen was observed on the 100 hall medication cart ready for use and was opened and undated. An interview was conducted with Nurse #2 on 04/28/16 at 11:45 AM who stated he administered 10 units of Levemir insulin to Resident #242 at 9:23 AM on 04/28/16 and used the undated	F 431	Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	

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F 431	Continued From page 39	F 431		

Levemir insulin FlexPen. Nurse #2 stated he forgot to check that the Levemir insulin FlexPen had an open date prior to administering Levemir insulin to Resident #242. Nurse #2 stated he had been in-serviced during orientation that insulin was required to be dated by nursing staff when opened to determine when insulin would expire. Nurse #2 stated whoever opened the Levemir insulin FlexPen should have dated the insulin when it was opened per facility protocol.

On 04/28/16 at 11:52 AM an interview was conducted with the Unit Director who verified that Levemir insulin FlexPen was on the 100 hallway medication cart and was ready for use for Resident #242 and was not dated when opened. The Unit Director stated all nurses had been in-serviced that insulin had to be dated when opened to determine the expiration date once the insulin was opened. The Unit Director immediately removed the Levemir insulin FlexPen from the 100 hallway medication cart.

On 04/28/16 at 12:08 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that nursing staff should have dated the Levemir insulin FlexPen for Resident #242 when it was opened. The DON stated her expectation was that nursing staff per facility protocol would have checked that Resident #242's Levemir insulin FlexPen was dated when opened prior to administering the Levemir insulin to Resident #242. The DON stated her expectation was that nursing staff would clarify with the DON or Unit Director if they were unsure of the facility protocol for opening and dating insulin.

On 04/28/16 at 2:55 PM an interview was

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F 431	Continued From page 40 conducted with the Administrator who stated the Levemir insulin FlexPen for Resident #242 should have been dated when opened. The Administrator stated staff should have verified that the insulin was dated prior to administering the Levemir insulin to Resident #242. 3. On 04/25/16 at 10:02 AM observations of a medication cart parked outside room 302 revealed the cart was unlocked and unattended. During the observation residents, staff and visitors were in the hallway with the unlocked medication cart. There was no nurse attending the medication cart. At 10:07 AM Nurse #3 approached the medication cart and was interviewed. Nurse #3 demonstrated that the medication cart was unlocked and stated that she had left momentarily to get supplies. She offered no explanation why she failed to secure her medication cart. On 04/28/16 at 3:08 PM the Director of Nursing (DON) was interviewed and stated that medication carts were to be locked when not in use. She added that a nurse was expected to lock a cart if the nurse had to leave the cart unattended.	F 431		
F 441 SS=E	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 -	F 441		5/24/16

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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 441	Continued From page 41 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to identify skin infections and maintain an infection control program to prevent residents and staff from contracting scabies in the facility for 4 of 5 residents reviewed for scabies (Residents #231, #36, #121 and #10). The findings included:	F 441	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of	

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F 441	Continued From page 42 A review of the facilities infection control manual dated 07/01/02 revealed the facilities guidelines to prevent and control the transmission of scabies read in part: precautionary measures included identification of contacts and contact isolation until the first treatment had been completed in the resident's assigned room. The infection control manual further indicated general instructions for application of treatment per Physician orders, laundry and room cleaning, disinfecting of gait belts and blood pressure (B/P) cuffs, remove upholstered furniture and cover with plastic for 7-10 days, and the distinction between Norwegian scabies and atypical scabies. Norwegian required isolation until after the second treatment and until 3 negative skin scrapings. Norwegian scabies if not treated effectively heavier infestation is noted by crusted thick lesions. Review of the facility infection control log from May 2015 through February 2016 revealed residents in different parts of the building with soft skin tissue (SST) irritations, rashes and scabies as follows: May 2015 revealed 11 cases of SST irritations and a resident with a rash on the 200 hall. June 2015 revealed 9 cases of SST irritations. July 2015 revealed 6 cases of SST irritations, and 1 case of scabies on the 500 hall. August 2015 revealed 8 cases of SST irritations and 1 case of scabies on the 400 hall. Sept 2015 revealed 8 cases of SST irritations and 1 case of scabies on the 500 hall. Oct 2015 revealed 13 cases of SST irritations and 1 case of scabies on the 500 hall. Nov 20 15 revealed 7 cases of SST irritations and 3 cases of scabies on the 400 hall. Dec 2015 reveals 7 cases of SST irritations.	F 441	compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Corrective Action: Resident #231, #36, #121 and #10. Resident #231 expired on 8/27/2015. Resident #36: On 4/27/2016 was treated with Elimite Cream prophylactically for scabies. Resident was immediately placed on contact isolation. On 4/28/2016 resident was assessed by attending physician. Skin scrapings done on 4/28/2016 which were sent to Solstas Lab for analysis. Resident was treated with Ivermection on 4/29/2016 and, 5/6/2016 5/13/2016. Resident was on Contact Isolation from 4/27/2016 to 5/14/2016. Resident #121: On 4/27/2016 was treated with Elimite Cream prophylactically for scabies. Resident was immediately placed on contact isolation. On 4/28/2016 resident was assessed by attending physician. Skin scrapings done on 4/28/2016 which were sent to Solstas Lab for analysis. Resident was treated with Ivermection on 4/29/2016 and 5/6/2016. Resident was on Contact Isolation from 4/27/2016 to 5/14/2016. Resident #10. On 4/28/2016, was assessed by a dermatologist. Skin scrapings were done by the dermatologist on 4/28/2016. Resident was immediately placed on contact isolation. On 4/28/2016 laboratory results were not definitive. Resident was treated with Ivermection on 4/29/2016 and 5/6/2016. Resident was on Contact Isolation from 4/27/2016 to	

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F 441	Continued From page 43 Jan 2016 reveals 2 cases of SST irritations. Feb 2016 reveals 7 cases of SST irritations. Review of the facility infection control log dated March 2016 revealed 3 cases of SST irritations. 1a. Resident #231 was admitted to the facility on 11/19/12 and expired in the facility on 08/27/15. Review of the medical record revealed Resident #231 was admitted with diagnoses that included heart failure, dementia, anxiety, depression, abnormal involuntary movements, malignant neoplasm of the skin, and insomnia. The quarterly Minimum Data Set (MDS) dated 08/15/15 indicated Resident #231 was severely impaired for daily decisions making and required extensive assistance with all activities of daily living (ADL) including assistance with bathing, toileting, dressing and personal hygiene. The MDS further revealed Resident #231 had no impairment to her upper and lower extremities. The MDS also revealed Resident #231 had a life expectancy of less than 6 months and received Hospice services. A review of the closed medical record for Resident #231 revealed the following documentation: Review of a physician order dated 05/07/15 an MD stated Triamcinolone Acetonide Cream (TAC) 0.1% to be applied to the body 2 times a day for a rash. Review of a medication administration record (MAR) dated 05/01/15 through 05/31/15 revealed no medications administered for scabies. Review of a treatment administration record (TAR) dated 05/01/15 through 05/31/15 revealed	F 441	4/30/2016. Facility immediately in serviced all staff (Full time, Part Time and PRN) about infection control, preventing spread of infection and CDC scabies education (recognizing, reporting and prevention of scabies) and also treatment of scabies with Ivermection, Elimite .All staff were in serviced about Contact precautions and use of PPE. Facility limited visitation for the next 72 hours while residents received prophylactic treatment for scabies. We also posted a sign at the front door letting visitors know we had an illness and for anyone with a rash or skin irritation to report to us. During this time the entire long term care unit was put on contact isolation by shutting the double doors, posting isolation signs, and providing personal protective equipment for all staff and visitors. Both dining rooms were closed during this time as well. Families were notified about this when they were called about the treatment. Staff received treatment as well. All rooms were deep cleaned, all clothing was washed, and any item not able to be washed was bagged and stored in a separate room for 72 hours. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All residents were treated prophylactically for scabies by 4/30/2016. Residents on the long term care hall received a second prophylactic treatment for scabies by 5/7/2016.	

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F 441	Continued From page 44 the cream was administered 2 times a day for rash. Review of a MAR dated 06/01/15 through 06/30/15 revealed no medications for scabies were administered. Review of a TAR dated 06/01/15 through 06/30/15 revealed TAC cream as applied to the torso twice a day for the entire month. Review of MAR dated 07/01/15 through 07/31/15 revealed no medications were administered for scabies. Review of TAR dated 07/01/15 through 07/31/15 revealed TAC cream was applied to the torso twice a day from 07/01/15 through 07/06/15 Review of the MAR dated 08/01/15 through 08/31/15 revealed no medications were administered for scabies. Review of the TAR dated 08/01/15 through 08/31/15 revealed no treatments were administered for scabies. An interview with nursing assistant (NA) #3 on 04/27/16 at 3:11 PM revealed that she recalled Resident #231 and recalled that she had skin problems with scabies. NA #3 further stated that if there was a scabies exposure the nurses informed them of who it was and what they were to do. NA#3 stated that she had went to the doctor for herself and her doctor completed a skin scraping and confirmed her suspicions of scabies and treated her for the issue. NA#3 stated that Nurse #4 who worked at the facility had examined her and stated to NA#3 that she did not have	F 441	Systemic Changes: Dr. Auffinger was educated by Dr. Herman, President of Physicians Eldercare, Board Member, by 5/24/2016. Director of Nursing and/or Designee in serviced all staff (full time, part time, and PRN) about infection control, preventing spread of infection and CDC scabies education (recognizing, reporting and prevention of scabies) and also treatment of scabies with Ivermection, Elimite .All staff were in serviced about Contact precautions and use of PPE. Education provided also included: Clinical and epidemiologic features of scabies, case management of scabies, prevention measures for scabies, environmental disinfection of scabies. This in services were completed on 5/24/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing weekly skin check assessments and ensuring that they are completed per policy and also ensure that there are no new soft skin tissue irritations, rashes and scabies. In the event that soft skin tissue	

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F 441	Continued From page 45 scabies that it was a heat rash but NA #3 stated she felt like she needed to see her doctor so she did. NA #3 stated that her coworkers were treated multiple times for scabies and most were quitting because of the continued issue. An interview with Nurse #3 on 04/28/2016 at 10:36 AM revealed that Resident #231 was treated many times with many different medicines, but it was always treatment for the same issue of a rash and itching. Nurse #3 further stated she could not recall if a skin scraping was completed but stated Resident #231 was being treated for presumed scabies. Nurse #3 stated she had reported the treatments were ineffective to the Director of Nursing (DON) and the Medical Doctor (MD) several times. An interview with Nurse #4 on 04/28/16 at 10:43 AM revealed she participated in the skin assessments of residents and staff for scabies. Nurse #4 further stated she reported her findings to the MD for further assessment and treatment orders. Nurse #4 explained she was in-serviced for assessing for the signs and symptoms of scabies, how to look for the rash, tracks and itching that indicate scabies. Nurse #4 further explained if treatments were ordered for a resident and the treatment was not effective she would report this to the MD. Nurse #4 revealed when a suspected case of skin infection was received she notified all direct care staff, she assisted with bagging personal items and clothes and notified housekeeping of the room that required deep cleaning. Nurse #4 further revealed residents and staff were treated for suspected scabies and some did not have scabies but were treated prophylactically.	F 441	irritations, rashes and scabies are identified, the facility will follow the appropriate care path. Physician will be immediately notified, Residents will be treated prophylactically for scabies, staff who have been in contact with affected residents will be treated prophylactically, families will be notified to seek medical attention if they've been in contact with affected resident, and residents would be put on contact isolation during treatment or according to CDC guidelines. The facility will also keep apparatus' (scapula and slides) to be used by physician for collecting specimens required to confirm scabies. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	

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An interview with the DON on 04/28/16 at 11:13 AM revealed that on 10/26/15 a resident went to the dermatologist and was diagnosed with scabies which is what prompted an investigation and treatment of residents of the facility. The DON further stated that all residents were treated with cream for scabies and the staff were educated and were provided with cream for treatment of scabies. The DON also stated that the residents on the rehab unit were given the option to receive treatment or not, but stated that they were all provided with education on the prevention of scabies. The DON did state that some of the resident on the rehab unit did decline the prophylactic treatment. The DON could not provide additional information of when or if the staff had been treated at any other times.

An interview with the MD on 04/28/16 at 2:01 PM revealed that concerns for residents are reported to her or one of the Nurse Practitioners (NP) by telephone or through the communication books, if it was an urgent matter we would call in orders, otherwise the resident would be seen during the next visit to the facility. The MD explained there were cases of scabies in the facility in the past and they were treated and they would be listed on the facility infection control log. The MD further explained the typical treatment for scabies was with Elimite cream and Ivermectin tablets by mouth, they were both onetime treatments but some dermatologists often recommend retreating 7 to 14 days after the initial treatment. TAC is used as an adjunct treatment for calming the inflammation and itching related to the skin condition. The MD stated "in my experience as a medical director scabies is common in facilities, it is sort of like an occupational exposure, and some people are more predisposed to getting

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scabies." The MD also stated that "scabies is a mere cosmetic irritant, and it can disappear and then have a resurgence." "I don't see the frequency of scabies being any different here than in any other facility I have been in, the important thing is to squash the hysteria associated with scabies."

Interview with the Administrator on 04/28/16 at 4:26 PM stated that there were no confirmed cases of scabies until November 2015 which prompted the facility to move forward with treating all the residents in the facility except for the rehab patients, it was optional to them. The administrator stated that the staff was in-serviced on procedures for isolation and deep cleaning of rooms that were afflicted by scabies or presumed scabies. The administrator stated that she expected the MD to be notified of itching or rashes or any treatment that was not effective for a resident.

b. Resident #36 was admitted to the facility on 04/20/15 with diagnoses which included dementia, osteoarthritis, hand contractures, joint stiffness, and unspecified disorder of the skin and subcutaneous tissue.

The annual Minimum Data Set (MDS) dated 03/14/16 indicated Resident #36 was moderately impaired for daily decision making and required extensive assistance with activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing. The MDS further revealed Resident #36 had impaired range of motion in upper and lower extremities on both sides and there were no skin rashes or lesions.

Review of the annual summary nurses notes

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dated 03/14/16 revealed Resident #36 was moderately impaired cognitively, had no signs of rejection of care, had contractures to her hands and required extensive assistance for all ADLs.

Review of a care plan updated on 03/14/16 revealed Resident #36 had a self-care performance deficit and required total assistance with ADLs. The ADL care plan goal was for the Resident #36 to improve current level of function with personal hygiene and the approaches were listed in part to assist Resident #36 and provide her needs.

Review of a physician order dated 04/20/16 indicated Triamcinolone Acetonide Cream 0/1% and apply to entire body twice daily for itching.

Review of a nurse's note dated 04/27/16 at 12:48 PM revealed Resident #36 continued to have a severe rash all over body with crusting in skin folds and between fingers and a red rash noted to her scalp, with hair falling out.

During an observation on 04/25/16 at 1:08 PM Resident #36 was observed in a Geri chair in her room. The skin between the fingers of both hands were observed with crusty flaky skin and all the fingernails had rough edges and crusty skin around the fingernails.

During an observation on 04/26/16 at 12:22 PM Resident #36 was in bed and observed with very dry and crusty looking skin on her face, arms, hand, and between her fingers.

During an observation on 04/27/16 at 1:22 PM Resident #36 was in bed and again observed to have very dry and crusty looking skin on her face,

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arms, hand, and between her fingers.

An interview on 04/27/16 at 5:54 PM with Nurse Aide (NA) #1 who was assigned to provide care for Resident #36 stated she required extensive assistance with all ADLs including, showers, grooming and personal hygiene.

An interview on 04/27/16 at 3:11 PM with NA #3 revealed she recalled Resident #36 had scabies. She explained when there was scabies exposure the nurses informed the Nurse Aides (NAs) which residents had scabies and what to do.

NA #3 further explained Resident #36 definitely had scabies because she went to a dermatologist who completed a skin scraping and diagnosed her and treated her for scabies. NA #3 revealed Resident #36 had the same crusty skin that looked like paste and was itching and scratching like other residents had who had been diagnosed with scabies. NA#3 further revealed she believed Resident #36 currently had scabies again because she had the same crusty itching skin as before and she had reported this to nurses 2 months ago.

An observation and interview on 04/28/16 at 9:07 AM revealed the Director of Nursing (DON) observed Resident #36 itching and verified they had placed her on contact precautions after the physician assessed her and had completed a skin scraping and treated her prophylactically for scabies pending the results. The DON stated it was her expectation for all residents to be clean, well groomed, and comfortable. The DON verified it was her expectation for all residents to have daily skin care, and nurses to report any skin conditions to the MD for assessment and

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treatment.

An interview on 04/28/16 at 10:43 AM with Nurse #4 revealed she had received in-service training to assess for the signs and symptoms of scabies, how to look for the rash, tracks and itching that indicated scabies. Nurse #4 further explained if treatments were ordered for a resident and the treatment was not effective she reported to the physician for further assessment and treatment orders. Nurse #4 explained when a suspected case of skin infection was received she notified all direct care staff, assisted with medications, bagged personal items and clothes and notified housekeeping when the room required deep cleaning.

A follow interview on 04/28/16 at 11:13 AM with the DON she verified Resident #36 had been placed on contact precautions today and was being treated for scabies as a precautionary measure pending the results of a skin scraping. The DON further verified the upholstered dining chairs in the resident's room was not supposed to be there and all furniture in resident rooms was to be vinyl or leather.

An interview on 04/28/16 at 2:01 PM with the facility Medical Director (MD) revealed typically concerns for residents were reported to her or the Nurse Practitioners (NP) by telephone or through the communication books. She explained if it was an urgent matter they called in orders but otherwise the resident was seen on the next visit at the facility either on Tuesday, Thursday or Friday. The MD confirmed there had been cases of scabies in the facility in the past and they were treated and were listed in the facility infection control log. The MD further explained the typical

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treatment for scabies was with Elimite cream and Ivermectin tablets by mouth. She stated both medications were one time treatments but some dermatologists recommend retreating. She explained Triamcinolone ointment (a steroid cream) was also used as an adjunct treatment for calming the inflammation and itching related to skin conditions. She further explained scabies was common in facilities and some residents were more predisposed to getting scabies and it was a cosmetic and irritant issue but it could disappear and then have a resurgence. She stated they had referred residents to different dermatologists (skin specialists) in the area but often treatment was delayed by 1-3 weeks to schedule the appointments. The MD further stated "in my experience as a medical director scabies is common in facilities, it is sort of like an occupational exposure, and some people are more predisposed to getting scabies." The MD also stated that "scabies is a mere cosmetic irritant, and it can disappear and then have a resurgence." "I don't see the frequency of scabies being any different here than in any other facility I have been in, the important thing is to squash the hysteria associated with scabies." The MD also explained Resident #36 was seen today by me for reported rashes she determined Resident #36 had an exfoliative dermatitis, received a skin scraping test and she would be surprised if the scraping was positive for scabies.

On 04/28/16 at 4:26 PM the Administrator was stated it was her expectation for all residents to be clean, well groomed, and comfortable. The Administrator further stated it was her expectation for all residents to have daily skin care and nurses should report any skin conditions to the physician for assessment and treatment. She

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explained there were no confirmed cases of scabies in the facility until November of 2015 and they treated all residents in the facility except it was optional for residents who lived on the 100 hall. She further explained it was her expectation for all resident's skin to be cleaned and lotioned and the physician or NP to be notified of itching or rashes. The Administrator confirmed there was still a problem with infection control regarding suspected scabies and confirmed residents still had skin issues and were itching and their treatments had been ineffective.

On 04/29/16 the laboratory tests results were received noting Resident #36's skin scraping tested positive for scabies.

c. Resident #121 was admitted to the facility on 11/25/14 with diagnoses which included disease of the nervous system, kyphosis, and depression.

The quarterly Minimum Data Set (MDS) dated 02/26/16 revealed Resident #121 was cognitively impaired for daily decision making and required extensive assistance with all activities of daily living (ADLs) including personal hygiene and bathing. The MDS further revealed Resident #121 had no skin rashes or lesions.
A review of a nurse ' s note dated 02/01/16 at 3:38 PM revealed Resident #121 had a raised red rash to back, buttocks, chest and stomach and complained of itching. The note further revealed the assessment was reported to the physician.
A review of a care plan updated on 02/26/16 revealed Resident #121 required assistance with the performance of ADLs due to the effects of the diagnosis of a nervous disorder. The ADL care plan goal was for Resident #121 to remain free of discomfort or complications related to the disease

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diagnosis and the approaches indicated in part to provide extensive assistance to Resident #121 for all ADLs.
A review of physician's order dated 03/12/16 indicated Triamcinolone Acetonide cream 0.l% and Eucerin and apply to pruritic (itchy) rash.
A review of a physician's order dated 03/09/16 indicated Benadryl 25 milligrams (mg) by mouth every 6 hours as needed for Itching.
A review of a physician's order dated 04/20/16 indicated Zeasorb powder for itching.
A review of a nurse's note dated 04/27/16 at 10:30 AM revealed Resident #121 was observed with her shirt lifted up and was scratching a rash covered area.
A review of a physician's order dated 04/27/16 indicated Elimite Cream 5 % (Permethrin) apply to body from head to toe once.
During an observation on 04/25/16 at 4:18 PM Resident #121 was observed scratching a rash on her arms, back and legs.

During an observation on 04/26/16 at 12:12 PM Resident #121 was up in her wheel chair in her room scratching under her right breast and her arms were observed with red and pink scratch marks.

During an observation on 04/26/16 at 4:49 PM Resident #121 was observed in her room scratching at the inner sides of her thighs.

During an observation on 04/27/16 at 9:15 AM Resident #121 was observed in her wheel chair with her shirt pulled up and was scratching her abdomen with her right hand.

During an observation and interview on 04/28/16 at 9:07 AM the Director of Nursing (DON)

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observed Resident #121 was scratching and verified they had just placed her on contact precautions after the physician had assessed her and completed a skin scraping and was treating her prophylactically for scabies pending the results. The DON stated it was her expectation for all residents to be clean, well groomed, and comfortable she expected for nurses to report any skin conditions to the physician for assessment and treatment.

During an interview on 04/28/16 at 3:08 PM with Nurse #3, who was assigned to care for Resident #121 explained Resident #121 had been provided Benadryl and ointments for itching by the physician but the treatments were effective only for a short time. She further explained Resident #121 had chronic itching and she had reported her rash and itching to the DON and the physician.

An interview on 04/28/16 at 2:01 PM with the facility Medical Director (MD) revealed typically concerns for residents were reported to her or the Nurse Practitioners (NP) by telephone or through the communication books. She explained if it was an urgent matter they called in orders but otherwise the resident was seen on the next visit at the facility either on Tuesday, Thursday or Friday. The MD confirmed there had been cases of scabies in the facility in the past and they were treated and were listed in the facility infection control log. The MD further explained the typical treatment for scabies was with Elimite cream and Ivermectin tablets by mouth. She stated both medications were one time treatments but some dermatologists recommend retreating. She explained Triamcinolone ointment (a steroid cream) was also used as an adjunct treatment for

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calming the inflammation and itching related to skin conditions. The MD stated " in my experience as a medical director scabies is common in facilities, it is sort of like an occupational exposure, and some people are more predisposed to getting scabies." The MD also stated that "scabies is a mere cosmetic irritant, and it can disappear and then have a resurgence." "I don't see the frequency of scabies being any different here than in any other facility I have been in, the important thing is to squash the hysteria associated with scabies." The MD also explained Resident #12 was seen today by me for reported rashes she determined Resident #121 rashes related to the fact that she gets yeasty. Resident #121 received a skin scraping test and she would be surprised if the scraping was positive for scabies. She stated they had referred residents to different dermatologists (skin specialists) in the area but often treatment was delayed by 1-3 weeks to schedule the appointments.

During an interview on 04/28/16 at 4:26 PM the Administrator stated it was her expectation for all residents to be clean, well groomed, and comfortable. She further stated all residents should have daily skin care and she expected for nurses to report any skin conditions to the physician for assessment and treatment.

On 04/29/16 the laboratory tests results were received noting Resident #121's skin scraping tested positive for scabies.

d. Resident #10 was admitted to the facility on 04/02/10 with diagnoses that included Alzheimer's disease and dementia. Review of the most recent quarterly MDS dated 04/12/16 revealed

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that Resident #10 was severely cognitively impaired for daily decision making and required extensive assistance with all ADLs and personal hygiene.

Review of dermatologist consultation report dated 06/08/15 read in part that Resident #10 was examined and found to have numerous skin eruptions to her arms, back, and legs with several burrowing patterns. The report further revealed a positive skin scraping for scabies. Resident #10 was treated for scabies.

Review of physician order dated 06/08/15 read Ivermectin 15 mg by mouth single dose and infection protocols to be implemented.

Review of physician order dated 02/14/16 read TAC 0.1% for itching twice a day.

Review of physician order dated 02/17/16 read Eucerin cream to skin for itching a needed.

Review of dermatologist consultation report dated 04/28/16 revealed Resident #10's was examined and a skin scraping was completed the clinical findings were consistent with scabies. The report further revealed she was being treated based on her physical exam and symptoms.

During an observation on 04/25/16 at 3:49 PM Resident #10 was observed scratching her arms. Scratch marks were present to both arms.

During an observation on 04/27/16 at 1:14 PM Resident #10 was observed scratching her arms while being transported in her wheel chair down the hall by her family representative to go to the dermatologist.

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F 441	Continued From page 57 On 04/28/16 at 9:07 AM the DON observed Resident #10 scratching both of her arms, and verified she was going to the dermatologist today with the Family representative (RP) The DON stated it was her expectation for all residents to be clean, well groomed, and comfortable. The DON verified it was her expectation for all residents to have daily skin care, and nurses to report any skin conditions to the MD for assessment and treatment. On 04/28/16 at 2:01 PM the MD was interviewed. The MD stated Resident #10 was seen by the NP this morning and was noted to have some scattered red dry areas to her left forearm and hand and was noted have dry skin. The MD further stated she believed this was a kind of photo dermatitis reaction. The MD and the NP explained there was possibly a miscommunication with the dermatologist and that the dermatologist didn't see anything and was only treating Resident #10 prophylactically, and was also the case in June. The MD further explained there was no skin scraping completed in June by the dermatologist and Resident #10 was treated for scabies and recommended everyone be treated. On 04/28/16 at 3:08 PM Nurse #3, who provided care for Resident #10 was interviewed. Nurse #3 revealed Resident #10 was treated in the past for scabies and was now provided ointments for itching as prescribed by the MD. Nurse #3 further revealed these treatments are effective but only for short times. The Nurse explained, Resident #10 had chronic itching and she had reported the itching the DON and the MD.	F 441		

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F 441	Continued From page 58 On 04/28/16 at 4:26 PM the Administrator was interviewed. The Administrator stated it was her expectation for all residents to be clean, well groomed, and comfortable. The Administrator verified it was her expectation for all residents to have daily skin care, and nurses to report any skin conditions to the MD for assessment and treatment. On 05/02/16 at 4:15 PM the Dermatologist (DM) was interviewed. The DM revealed she assessed Resident #10 on 04/28/16 and completed a skin scraping which was not definitive. The DM further revealed a person could have scabies and have all the symptoms but still have a negative scraping and in this case Resident #10 had all the classic skin symptoms of itching, burrows, and flaking skin. She was "a clinical dead ringer for scabies". The DM explained Resident #10 was also seen in June 2015 had a positive skin scraping for scabies and was treated and recommended the facility treat everyone at that time. The DM further explained that she does not physically go into facilities but based on this resident's reinfection there appears to be a concern. The facility may be properly treated the infected resident and their room, but the concern would be thorough treatment of the common areas, staff and visitors in order to prevent someone transmitting it to other areas and other persons. If there were a suspected rash and itching with the possibility of being scabies there was no harm in treating the person prophylactically to ensure that it was not spread.	F 441		
F 500 SS=B	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified	F 500		5/24/16

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F 500	Continued From page 59 professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain a written agreement for services provided by an outside provider for 2 of 2 residents (Residents # 39 and 162) receiving dialysis services and the residents received dialysis without a contract in place. The findings included: The recertification survey was held on 04/25/16 through 04/28/16. On 04/25/16 the facility provided a list of 2 residents in the facility receiving outside hemodialysis services. The facility provided a document titled "Dialysis Services Agreement" that read in part, "This Dialysis Services Agreement is entered into effective April 27, 2016." On 04/27/16 at 3:46 PM the Administrator was interviewed and reported her "boss" reviewed contracts. She stated that there should have been a dialysis contract in place but it was unable	F 500	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F500 OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/ARGMT Corrective Action: Residents #39 and # #162 Residents #39 and # #162 received dialysis services from an outside provider. A Dialysis Service Agreement /contract	

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F 500	Continued From page 60 to be located. She added that the dialysis center was also unable to locate the contract and a new one was developed on 04/27/16.	F 500	was developed and put in place immediately. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done Jessica McCollum, NHA on 4/27/2016 to ensure that agreements/contracts were in place pertaining to any services furnished by outside resources. Systemic Changes: QA Consultant in-serviced Administrator that if the facility does not employ a qualified professional person to furnish a specific service the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement or an agreement. Arrangements or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. All residents receiving dialysis services from an outside provider, must have a contract in place for the dialysis services. This in service was completed on 5/18/2016. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by reviewing contracts for any services provided by outside resources. This will be done on quarterly basis. This will be	

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F 500	Continued From page 61	F 500	discussed/ presented to the monthly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Monthly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 5/24/2016	