

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345036</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH CITY HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909</b>	
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility staff failed to sit while assisting residents with meals and/or failed to answer call lights timely for 5 of 5 sampled residents reviewed for dignity (Residents #33, 131, 154, 306 and 307). Findings included:</p> <p>1. Resident #154 was admitted to the facility on 2/17/16 with diagnoses that included cerebrovascular disease, diabetes, depression, affective mood disorder, dependent personality disorder and hemiplegia.</p> <p>The 5/11/16 Quarterly Minimum Data Set indicated Resident #154 was cognitively intact, had no behaviors and required extensive assistance for bed mobility, transfer, toilet use and personal hygiene. He was assessed as frequently incontinent of urine and usually continent of bowel.</p> <p>An interview was held with Resident #154 on 6/28/16 at 5:50 PM. The resident stated at times he was left on the bedpan for 45 minutes to an hour. He stated he knew it was that long because he could look at the clock hanging in his room. The resident stated it was mostly the 3:00</p>	F 241	<p>Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.</p> <p>F241</p> <p>The facility will 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 by ensuring call bells are answered timely and staff sit while feeding residents.</p> <p>Resident #154 was interviewed by the Social Worker on 7/23 /16 with resident indication that there has been improvement in call bell response time and that needs are addressed when the call bell is answered.</p> <p>Residents #33 and #131 were interviewed by the Social Worker on 7/26 /16 with resident indication that there has been</p>	7/28/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/27/2016

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 241	<p>Continued From page 1</p> <p>PM to 11:00 PM shift and had happened most recently over the weekend. The resident stated at other times, the staff would come in, turn the light off and come back when they felt like it, without answering his need. On 6/28/16 at 5:55 PM, Resident #154 was observed to activate his call light. While waiting for staff to respond to the resident ' s call light, voices could be heard passing the room, and shadows of feet were seen passing the door without stopping into the room to ask what the resident needed. The resident stated it was normal for staff to pass his room, but not stop to see what was needed. At 6:05 PM, the call light was answered.</p> <p>Nurse #10 was interviewed on 6/30/16 at 2:05 PM. She stated there was not enough nurses or nursing assistants (NAs) in the facility. She stated NAs were only able to turn and position residents and provide incontinent care every 4-5 hours adding that weekends were even worse and the 3:00 PM to 11:00 PM shift was the worst shift. The nurse added at times, it took more than the expected 5 minutes to 15 minutes to answer the call lights.</p> <p>On 6/30/16 at 2:23 PM, Nursing Assistant (NA) #3 was interviewed. The NA stated her ability to check for incontinence and turn and position residents depended on the number of residents she was assigned. NA #3 stated when assigned 13 residents she provided incontinent care when she provided their bath and then provided incontinent care one more time before going home. Turing and positioning was done at the same time; usually every 3-4 hours. The NA stated she felt the facility was absolutely short staffed which made it almost impossible to bathe, feed residents, provide incontinent care and turn</p>	F 241	<p>improvement in call bell response time and that needs are addressed when the call bell is answered.</p> <p>Resident #307 discharged from the facility on 7/3/16 and was not available for an interview.</p> <p>Nursing Assistant #4 was reeducated by the Director of Nursing on 7/21/16 related to promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of his or her individuality by ensuring that she is seated at eye level with residents when she is feeding them.</p> <p>100% of facility staff were reeducated by the Director of Clinical Operations, Director of Nursing, and the Quality Assurance Nurse beginning 7/1/16 related to the need for decreased response time to resident call bells and to ensure call lights are not turned off until the resident need is met to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of his or her individuality. The reeducation also included all staff may answer call bells and should not walk past a call bell without responding to the resident need. Unlicensed and noncertified staff may request additional staff assistance as needed. The inservice will be completed by 7/28/16. No staff member will be allowed to work until the inservice has been signed. All newly hired staff will</p>		

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F 241	<p>Continued From page 2 and position as the residents required.</p> <p>NA #6 was interviewed on 6/30/16 3:32 PM. The NA stated while assigned 12 residents on the current shift, the usual work load for the 3:00 PM to 11:00 PM shift was 14 to 16 residents per NA. The NA added some residents took almost an hour to get ready for bed, which made completing work difficult. The NA added checking for incontinence and turning and positioning residents every 2 hours was impossible and most of the time only 2 incontinent checks per shift were completed.</p> <p>On 6/30/16 at 3:47 PM, NA #7 was interviewed. The NA stated recently staff had been cut. Most of the time, the NA stated the usual work load was 15 residents per NA. The NA stated it was virtually impossible to get all residents fed timely and provide incontinence rounds every 2 hours. At times, everyone has not been fed their evening meal until 7:30 PM. The NA stated it was impossible to answer call lights in the expected time of 10 minutes to 15 minutes.</p> <p>Nurse #4 was interviewed on 6/30/16 at 4:04 PM. She stated staffing had been horrible since the new company took over. NAs on each unit had been decreased from 4 NAs to 3 and sometimes the unit would only have 2 NAs. The nurse stated while staff did the best they could, she was sure incontinent rounds were not being made as needed and call bells were not answered as quickly as they should have been.</p> <p>The Director of Nursing (DON) was interviewed on 6/30/16 at 4:29 PM. The DON reviewed the staffing pattern before and after the facility transitioned from one company to another and</p>	F 241	<p>receive the inservice during orientation.</p> <p>All Licensed and certified staff were reeducated by the Director of Nursing or the Quality Assurance Nurse and the Director of Clinical Operations beginning 7/1/16 to assure staff feed residents while seated in order to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in recognition of his or her individuality. The inservice will be completed by 7/28/16. No staff member will be allowed to work until the inservice has been signed. All newly hired staff will receive the inservice during orientation.</p> <p>All staff members were inserviced by the Social Services Worker beginning 7/1/16 to assure to Resident Dignity and Respect and Resident Rights are observed by all staff. The inservice will be completed by 7/28/16. The inservice will be added to the facility orientation packet. Staff will not be allowed to work until inservice is signed.</p> <p>All alert and oriented residents were interviewed by the Social Services Department on 7/5/16 related to their feelings of being treated with dignity and respect by the staff and if they feel their call bells are answered in a reasonable amount of time. Any concerns were written on a Resident Concern Form and addressed through the grievance process.</p> <p>The Assistant Administrator, Quality Assurance Nurse, Unit Manager, Staff</p>		

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F 241	<p>Continued From page 3</p> <p>acknowledged there had been a decrease in staffing.</p> <p>2. Resident #307 was admitted to the facility on 6/13/16 with diagnoses that included hypertension, ataxia following cerebral infarction, chronic obstructive pulmonary disease, cataract and degenerative disease of the nervous system.</p> <p>The 6/20/16 Admission Minimum Data Set indicated Resident #307 was cognitively intact. There were no mood indicators or behaviors identified. The resident was identified as requiring extensive assistance for transfer, toilet use and personal hygiene.</p> <p>Resident #307 was interviewed on 6/27/16 at 5:27 PM. She stated when she was first admitted she had been instructed not to get up alone. She stated while she recognized the dangers of a possible fall, since it took so long for staff to respond to call lights, she would rather chance a fall than wet herself.</p> <p>Nurse #10 was interviewed on 6/30/16 at 2:05 PM. She stated there was not enough nurses or NAs in the facility. She stated NAs were only able to turn and position residents and provide incontinent care every 4-5 hours adding that weekends were even worse and the 3:00 PM to 11:00 PM shift was the worst shift. The nurse added at times, it took more than the expected 5 minutes to 15 minutes to answer the call lights.</p> <p>On 6/30/16 at 2:23 PM, Nursing Assistant (NA) #3 was interviewed. The NA stated her ability to check for incontinence and turn and position residents depended on the number of residents she was assigned. NA #3 stated when assigned</p>	F 241	<p>Development Coordinator or Social Services Department will use the Call Bell/Feeding/Sanitation Audit Tool to ensure call bells are being responded to timely. The above mentioned department heads will interview/observe 8 residents daily x 14 days, to include all shifts, then 8 residents daily Monday -Friday x 2 weeks, then 8 residents weekly x 4 weeks, then 8 residents monthly x 1 to ensure call bells are being answered timely. Resident concerns will be addressed through the Resident Concern Process. Staff will be reeducated immediately as issues are identified.</p> <p>The results of the interviews will be reviewed and initialed by the Director of Nursing weekly x 8 weeks, then monthly x 1.</p> <p>The Executive Quality Assurance Committee will review the results of the audits monthly x 3 to determine the continued frequency and need for monitoring.</p> <p>The Assistant Administrator, Quality Assurance Nurse, Unit Manager, Staff Development Coordinator or Social Services Department will use the Call Bell/Feeding/Infection Control Audit Tool. The above mentioned department heads will observe 8 residents daily x 14 days (to include all meals), then 8 residents daily Monday-Friday x 2 weeks, 8 residents weekly x 4 weeks, then 8 residents monthly x 1 month to ensure employees are seated while feeding residents. Staff</p>		

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F 241	<p>Continued From page 4</p> <p>13 residents she provided incontinent care when she provided their bath and then provided incontinent care one more time before going home. Turing and positioning was done at the same time; usually every 3-4 hours. The NA stated she felt the facility was absolutely short staffed which made it almost impossible to bathe, feed residents, provide incontinent care and turn and position as the residents required.</p> <p>NA #6 was interviewed on 6/30/16 3:32 PM. The NA stated while assigned 12 residents on the current shift, the usual work load for the 3:00 PM to 11:00 PM shift was 14 to 16 residents per NA. The NA added some residents took almost an hour to get ready for bed, which made completing work difficult. The NA added checking for incontinence and turning and positioning residents every 2 hours was impossible and most of the time only 2 incontinent checks per shift were completed.</p> <p>On 6/30/16 at 3:47 PM, NA #7 was interviewed. The NA stated recently staff had been cut. Most of the time, the NA stated the usual work load was 15 residents per NA. The NA stated it was virtually impossible to get all residents fed timely and provide incontinence rounds every 2 hours. At times, everyone has not been fed their evening meal until 7:30 PM. The NA stated it was impossible to answer call lights in the expected time of 10 minutes to 15 minutes.</p> <p>Nurse #4 was interviewed on 6/30/16 at 4:04 PM. She stated staffing had been horrible since the new company took over. NAs on each unit had been decreased from 4 NAs to 3 and sometimes the unit would only have 2 NAs. The nurse stated while staff did the best they could, she was sure</p>	F 241	<p>will be reeducated immediately as issues are identified.</p> <p>The results of the audits will be reviewed and initialed by the Director of Nursing weekly x 8 weeks, then monthly x 1.</p> <p>The Executive Quality Assurance Committee will review the results of the audits monthly x 3 to determine the continued need and frequency for monitoring.</p>		

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F 241	<p>Continued From page 5</p> <p>incontinent rounds were not being made as needed and call bells were not answered as quickly as they should have been.</p> <p>The Director of Nursing (DON) was interviewed on 6/30/16 at 4:29 PM. The DON reviewed the staffing pattern before and after the facility transitioned from one company to another and acknowledged there had been a decrease in staffing.</p> <p>3. Resident #33 was admitted to the facility on 12/27/13. Diagnoses included hypertension, heart failure and depression.</p> <p>The most recent Minimum Data Set, a quarterly dated 4/28/16, indicated Resident #33 was cognitively intact and required extensive assistance with bed mobility, transfer, dressing and personal hygiene.</p> <p>During an interview with Resident #33 on 6/28/16 at 9:42 AM, the resident stated since the new company took over the facility, staffing had gone down and wait time for services had increased since call bell response was slower. The resident added at times, it was at least 11:00 AM or after lunch before he received his bath and was assisted out of bed. The resident stated he preferred to be up before 11:00 AM.</p> <p>Observations made on 6/30/16 at 12:15 PM, revealed Resident #33's bath had just been completed and he was being assisted out of bed by Nursing Assistant #3.</p> <p>Nursing Assistant (NA) #3 was interviewed on 6/30/16 at 2:23 PM. NA #3 acknowledged Resident #33 required assistance with bathing,</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>dressing, toilet use and transfer to his wheelchair. She added Resident #33 was her fifth bath that day and she had 6 more baths to give before going home. The NA stated she was only able to give care in the morning and then check on residents once more before going home. NA #3 added she usually started baths with those residents who had appointments and others got their baths as she got to them. The NA stated residents had complained about the wait time for care.</p> <p>The Director of Nursing (DON) was interviewed on 6/30/16 at 4:29 PM. The DON reviewed the staffing pattern before and after the facility transitioned from one company to another and acknowledged there had been a decrease in staffing.</p> <p>4. Resident #131 was readmitted to the facility on 5/23/16 with diagnoses that included hypothyroidism, dementia, major depressive disorder, anxiety and hypertension.</p> <p>Review of the 6/13/16 Quarterly Minimum Data Set indicated Resident #131 was cognitively intact with no behaviors documented. Resident # 131 required extensive assistance for toilet use and personal hygiene.</p> <p>During an interview with Resident #131 on 6/28/16 at 8:46 AM, she stated at night she sometimes waits for over an hour for assistance with toileting and had in the past wet herself. She stated wetting herself is humiliating.</p> <p>Nurse #10 was interviewed on 6/30/16 at 2:05 PM. She stated there was not enough nurses or NAs in the facility. She stated NAs were only</p>	F 241			

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F 241	<p>Continued From page 7</p> <p>able to turn and position residents and provide incontinent care every 4-5 hours adding that weekends were even worse and the 3:00 PM to 11:00 PM shift was the worst shift. The nurse added at times, it took more than the expected 5 minutes to 15 minutes to answer the call lights.</p> <p>On 6/30/16 at 2:23 PM, Nursing Assistant (NA) #3 was interviewed. The NA stated her ability to check for incontinence and turn and position residents depended on the number of residents she was assigned. NA #3 stated when assigned 13 residents she provided incontinent care when she provided their bath and then provided incontinent care one more time before going home. Turing and positioning was done at the same time; usually every 3-4 hours. The NA stated she felt the facility was absolutely short staffed which made it almost impossible to bathe, feed residents, provide incontinent care and turn and position as the residents required.</p> <p>NA #6 was interviewed on 6/30/16 3:32 PM. The NA stated while assigned 12 residents on the current shift, the usual work load for the 3:00 PM to 11:00 PM shift was 14 to 16 residents per NA. The NA added some residents took almost an hour to get ready for bed, which made completing work difficult. The NA added checking for incontinence and turning and positioning residents every 2 hours was impossible and most of the time only 2 incontinent checks per shift were completed.</p> <p>On 6/30/16 at 3:47 PM, NA #7 was interviewed. The NA stated recently staff had been cut. Most of the time, the NA stated the usual work load was 15 residents per NA. The NA stated it was virtually impossible to get all residents fed timely</p>	F 241			



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F 241	<p>Continued From page 8</p> <p>and provide incontinence rounds every 2 hours. At times, everyone has not been fed their evening meal until 7:30 PM. The NA stated it was impossible to answer call lights in the expected time of 10 minutes to 15 minutes.</p> <p>Nurse #4 was interviewed on 6/30/16 at 4:04 PM. She stated staffing had been horrible since the new company took over. NAs on each unit had been decreased from 4 NAs to 3 and sometimes the unit would only have 2 NAs. The nurse stated while staff did the best they could, she was sure incontinent rounds were not being made as needed and call bells were not answered as quickly as they should have been.</p> <p>The Director of Nursing (DON) was interviewed on 6/30/16 at 4:29 PM. The DON reviewed the staffing pattern before and after the facility transitioned from one company to another and acknowledged there had been a decrease in staffing.</p> <p>5. Resident #306 was admitted on 6/9/16. Minimum Data Assessment information was not available. Nursing staff identified the resident as cognitively impaired and requiring extensive to total assistance for all activities of daily living.</p> <p>On 6/28/16 at 8:35 AM, Nursing Assistant (NA) #4 was observed standing to feed Resident #306. An empty chair was observed on the other side of the bed and was available to the NA for use.</p> <p>NA #4 was interviewed on 6/29/16 2.20 PM. She stated she had been taught to sit down when feeding residents so she would be on eye level.</p>	F 241			

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F 241	Continued From page 9 The NA stated she had not sat down to feed the resident because then her feet would hurt and she would not want to get back up. The NA did not see standing as a dignity issue and stated she needed to stand to see if the resident was choking.	F 241			
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278		7/28/16	

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NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH CITY HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909</b>		
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F 278	Continued From page 10  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) for 4 of 25 sampled residents (Residents #57, #131, #307, #227) whose MDS was reviewed. Findings included: 1. Resident #57 was admitted to the facility 11/18/12 with diagnoses which included diabetes, dementia, sleep apnea, hypertension, coronary artery disease, and asthma. Her quarterly MDS of 2/23/16 revealed she required limited assistance with eating, and toilet use and extensive assistance with bed mobility, transfers, dressing, personal hygiene and bathing. Her annual MDS of 5/10/16 indicated she was moderately cognitively impaired. She was coded as requiring limited assistance with bed mobility, transfers and toilet use. She required extensive assistance with eating, dressing, personal hygiene and bathing. A review of her care plan dated 3/3/16 revealed a self-care deficit related to impaired mobility with goals to dress and bath self with extensive assistance. There were no care plans indicating the resident required extensive assistance with eating. On 6/27/2016 at 12:52PM, Resident #57 was observed sitting in her room feeding herself lunch.  On 06/28/2016 at 8:54 AM, Resident #57 was	F 278	F278  Resident #57 <input type="checkbox"/> On 6/30/16 a modification of the record by the MDS nurse was made to her Annual MDS dated 5/10/16 correctly indicating she required set up assistance only with feeding and can feed herself independently.  Resident #227- On 6/30/16 a modification of the record by the MDS nurse was made to her MDS assessment dated 5/17/16 and a diagnosis of Depression was added to the MDS.  Resident #131- On 6/30/16 a modification of the record by the MDS nurse was made to the 6/13/16 Quarterly MDS indicating the resident has an indwelling catheter present.  Resident #307-on 6/30/16 the 5 Day Assessment was corrected by the MDS nurse to include a diagnosis of depression.  All modifications were transmitted to CMS on 7/26/16 by the MDS Coordinator.  A one-hundred percent audit of MDS coding of all resident <input type="checkbox"/> s most recent MDS, utilizing an MDS audit tool, was completed		

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F 278	<p>Continued From page 11</p> <p>observed sitting in her room feeding herself breakfast.</p> <p>On 6/29/16 at 4:11 PM, an interview was conducted with the MDS Coordinator, she stated the information for the Activities of Daily Living section of the MDS is obtained by interviewing residents and Nursing Assistants (NA) as well as reviewing the information charted on the kiosk computer. She further stated that if the documentation showed a significant change, the MDS nurse would investigate to see if the NA felt the resident needed to be coded that way because she had to give extra help. She also stated that the MDS staff would interview the NA that was working with the resident during the Assessment Reference Dates (ARD) and if they indicated there was a coding error, the MDS nurse would document there was incorrect coding.</p> <p>On 6/30/16 at 10:20 AM, an interview was conducted with NA #1. She stated she was familiar with Resident #57's care needs. She stated there had been no significant changes in her care over the past 6 months. She also indicated that Resident #57 required no assistance with feeding. She stated that she would document in the computer that the resident required set up assistance because she liked her coffee heated up.</p> <p>On 6/30/16 at 1:39 PM, Resident #57 was observed sitting in her room feeding herself. She stated she has always been able to feed herself.</p> <p>On 6/30/16 at 2:08 PM, a second interview was conducted with the MDS coordinator. She stated there must have been an oversight. She indicated</p>	F 278	<p>by the contracted MDS nurse, Quality Assurance Nurse and Assistant Director of Nursing on all areas of the MDS on 7/21-23/16 to include coding of eating, coding of depression and coding of indwelling catheters. All coding errors found were addressed with a modification. All modifications were transmitted to CMS on 7/26/16 by the MDS Coordinator.</p> <p>The four current MDS nurses were re-educated by the Director of Clinical Services on 7/20/16 related to coding the MDS assessment to accurately reflect the current status of the resident. The four current MDS nurses reviewed the RAI manual in its entirety as part of their re-education on coding the MDS assessments accurately by 7/20/16.</p> <p>The Quality Assurance Nurse or Unit Manager will review 2 random MDS assessments weekly x 12 weeks to ensure the coding of the MDS assessment accurately reflects the current condition of the resident.</p> <p>The DON will print a copy of the MDS reviewed and initial it as correctly coded as part of the audit weekly x 12 weeks.</p> <p>The results of the audits will be presented to the Executive QI Committee monthly x 3 to determine the continued need and frequency for monitoring.</p>		

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F 278	<p>Continued From page 12</p> <p>that she was not aware of any changes in Resident #57's level of functioning regarding eating.</p> <p>On 6/30/16 at 2:10 PM, the Director of Nursing was interviewed. She stated she was familiar with Resident #57 and that she has always been able to feed herself without assistance. She stated that information is gathered through data collected from the computer and from resident interview. She further stated that it is her expectation that the MDS nurses make sure the MDS is coded correctly.</p> <p>2. Resident #277 was admitted to the facility on 12/17/2015 with diagnoses to include dementia, heart disease and falls.</p> <p>A review of the Resident's Psychiatric evaluation dated 5/11/2016, revealed that Lexapro (an anti-depressant) would be given to the resident for depression.</p> <p>A physician order dated 5/11/2016 for Lexapro 10 milligrams daily.</p> <p>A review of the residents Medication Administration Record (MAR) for May 2016 revealed the resident received Lexapro daily starting on 5/12/2016.</p> <p>The resident's Minimum Data Set (MDS) assessment dated 5/27/2016 revealed the resident was on an antidepressant for 7 days during the look back period. There was no diagnoses of depression listed on the MDS.</p> <p>On 6/30/2016 at 10:03 AM, an interview was conducted with the MDS nurse (nurse #1). The MDS nurse stated she missed the diagnoses of depression on the assessment.</p> <p>On 6/30/2016 at 3:58 PM, an interview was conducted with the Administrator, who stated she</p>	F 278			

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F 278	<p>Continued From page 13</p> <p>expected the MDS assessment to be accurate</p> <p>3. Resident #131 was re-admitted to the facility on 5/23/16 with diagnoses that included hypothyroidism, Alzheimer's disease, hypertension, osteoarthritis and adult failure to thrive. The diagnoses list in the electronic medical record did not list a diagnosis to support the use of an indwelling urinary catheter.</p> <p>The hospital discharge summary, dated 5/23/16, indicated during hospitalization Resident #131 had an indwelling urinary catheter placed due to having urinary retention. The summary added the resident had failed 3 voiding trials and the indwelling urinary catheter remained.</p> <p>Review of the 6/13/16 Quarterly Minimum Data Set (MDS) indicated Resident #131 was cognitively intact and required extensive assistance for toilet use and personal hygiene. The use of an indwelling urinary catheter was not identified.</p> <p>Resident #131 was interviewed on 6/29/16 at 8:45 AM. The resident stated the indwelling urinary catheter had been placed during her recent hospitalization because she had been unable to void.</p> <p>The MDS Coordinator was interviewed on 6/30/16 at 11:13 AM. The Coordinator stated if a resident had a urinary catheter, it should be coded on the MDS. The Coordinator reviewed the most recent MDS for Resident #131 and acknowledged her catheter had not been coded. She stated not coding the use of the catheter for Resident #131 was an error.</p>	F 278			

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F 278	Continued From page 14  4. Resident # 307 was admitted to the facility on 6/13/16 with diagnoses that included hypertension, ataxia following cerebral infarction and cataracts.  The 6/13/16 hospital discharge summary indicated the resident received Remeron (an antidepressant) at bedtime. Facility orders, dated 6/13/16 also indicated the resident received Remeron 30 milligrams at bedtime.  The 6/20/16 Admission Minimum Data Set (MDS) indicated Resident #307 was cognitively intact. There were no mood indicators or behaviors identified. Depression was not identified as active diagnoses.  During an interview with Resident #307 on 6/29/16 at 2:30 PM, she stated she had been taking the Remeron for about 2 years due to depression after the loss of a family member.  The MDS Coordinator was interviewed on 6/30/16 at 11:13 AM. She stated if the physician had noted a diagnosis of depression, then depression should have been coded. The MDS Coordinator reviewed the MDS for Resident #307 and acknowledged not coding depression was an oversight.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care	F 279		7/28/16	

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F 279	<p>Continued From page 15</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a care plan to address hospice and end of life issues for 1 of 1 sampled resident (Resident #275) reviewed for hospice services.</p> <p>Findings included:</p> <p>Resident # 275 was readmitted on 5/9/16 with diagnoses that included atrial fibrillation, dementia palliative care, hypertension and heart attack.</p> <p>Review of notes indicated hospice services were initiated on 5/10/16.</p> <p>The Change in Condition Minimum Data Set (MDS), dated 5/16/16, indicated Resident #275 was cognitively impaired and required extensive to total assistance for all activities of daily living.</p>	F 279	<p>F279</p> <p>The care plan for Resident #275 was revised by the MDS nurse on 6/30/16 to reflect the resident's end of life wishes and hospice services. However, new orders were received 7/15/16 to discontinue Hospice services, and the care plan for hospice services was discontinued by the MDS Nurse on 7/16/16.</p> <p>A 100% audit of residents' most recent care plans was completed by the company contracted MDS nurse, Director of Nursing, Quality Assurance Nurse and ADON of resident care plans on 7/23/16 to include care planning of hospice services. An MDS Audit Tool was used to complete the audit.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 16 Resident #275 was identified on the MDS as receiving hospice services.  Review of Resident #275's care plan, last reviewed on 6/1/16, failed to reveal a care plan identifying the resident's wish for end of life care with measurable goals and interventions.  The MDS Coordinator was interviewed on 6/30/16 at 11:15 AM. She acknowledged Resident #275 received hospice services and those services should be care planned. The MDS nurse reviewed the care plan for Resident #257 and acknowledged the resident's end of life wishes and hospice services had not been care planned.	F 279	The four current MDS nurses were re-educated to assure end of life wishes and hospice services are care planned on 7/26/16 by the Director of Clinical Operations.  The Quality Assurance Nurse or Unit Manager will review 1 hospice resident care plan weekly x 12 weeks to ensure the care plan accurately reflects resident's end of life wishes and hospice services.  The Director of Nursing will review and initial the audit tool for trends and concerns weekly x 12 weeks.  The results of the care plan audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency of monitoring.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 309		7/28/16	
		F 309			

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F 309	<p>Continued From page 17</p> <p>interviews, and record review, the facility failed to obtain a medication per a physician ' s order for 1 of 3 residents (Resident #309) reviewed for pain recognition and management.</p> <p>Findings included: Resident #309 was admitted to the facility 6/15/16 with diagnoses which included diabetes, sleep apnea, post-traumatic stress disorder, transient ischemic attacks and kidney failure. The Admission Minimum Data Set had not yet been completed. A review of the hospital discharge summary dated 6/15/16 revealed an order for Tylenol #4 (a combination non-narcotic/narcotic pain reliever) to be given by mouth at bedtime. A review of the nurse ' s daily note for 6/16/16 at 4:34 PM stated " according to the pharmacy, client ' s request for med were not submitted until 6:15 PM on 6/15/16 will not receive his meds until this pm. " Further review of the nurse ' s daily note for 6/19/16 at 11:21 PM indicated the resident " had an order for Tylenol #4 which had not come from the pharmacy yet. Oncoming nurse is aware and will pass it on to 7 to 3 nurse. "</p> <p>A care plan dated 6/16/16 listed impaired mobility, aging/disease processes, use of psychotropic drugs with potential for pain, falls and adverse effects with a goal that pain would be relieved within 45 minutes. Interventions included administer medications as ordered and to notify the physician if unable to alleviate pain or if pain medications were ineffective. The Director of Nursing provided the 24 hour report for 6/23/16 for Resident #309. A handwritten note read " fax (unreadable) for Tylenol #3. " The 24 hour report for 6/24/16 for Resident #309 had a handwritten note stating " need hard script Tylenol #4. "</p>	F 309	<p>Resident # 309 was discharged on 7/1/16.</p> <p>A 100% medication audit was completed on each resident on 7/24-7/25/16 by the Assistant Director of Nursing and Unit Manager to ensure all residents on medications requiring a written prescription had the medications in the facility and that all non-narcotic medications were available in the cart.</p> <p>100% of all licensed nurses will be reeducated by the Director of Clinical Operations, Staff Development Coordinator, or the Quality Assurance Nurse by 7/28 /16 to assure the nurses understanding of the need to obtain a written prescription to send to the facility pharmacy for medications requiring a written prescription. If a nurse sees documentation on the Medication Administration Record for greater than 24 hours that a medication has not been administered, the physician must be contacted to obtain a written prescription. When a medication is not available for administration, the physician should be contacted for a substitute order for medication that is available until the ordered medication arrives in the facility for administration. A nurse will not be allowed to take a cart until this inservice is complete. All newly hired nurses will receive the inservice during orientation.</p> <p>The Quality Assurance nurse or MDS nurse will review all physician orders to assure all medications requiring a written</p>		

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F 309	<p>Continued From page 18</p> <p>A review of the electronic Medication Administration Record (eMAR) revealed Tylenol #4 was not administered (marked N) from 6/15/16 to 6/26/16.</p> <p>An interview was conducted with Resident #309 on 6/28/16 at 12:47 PM. He stated he had neck pain that was unrelieved by the Tylenol #4 that was ordered. He also reported it had taken over a week to "get the order" for Tylenol #4</p> <p>An interview was conducted 6/30/16 at 8:07 AM with Nursing Assistant #2 (NA). She stated Resident #309 had not expressed any complaint of pain to her.</p> <p>An interview was conducted 6/30/16 at 8:11 AM with Nurse #3. She stated she was familiar with Resident #309. She stated she would assess the resident's pain on morning rounds and with medication pass. She stated Resident #309 had not voiced any complaint of pain to her.</p> <p>Resident #309 was observed on 6/30/16 at 10:15 AM lying in bed with his eyes closed. No visible indication of pain was observed.</p> <p>An interview was conducted 6/30/16 at 3:04 PM with Nurse #4. She stated she was PRN (scheduled as needed, not a regular staff person) and had not worked with Resident #309. She stated if a medication was not available, she would look in the back up medication system. If it was not available in the system, she would call the ordering physician for a hard (written) prescription. She further stated if she could not obtain a hard prescription, she would call the physician to get a temporary order for an available medication until the ordered medication could be filled. She stated if orders were faxed to the pharmacy before 5:00 PM, the medication should be received. If not ordered by 5:00 PM, it would be the next day before they arrived.</p> <p>An interview was conducted on 6/30/16 at 3:22</p>	F 309	<p>prescription have the written prescription sent to the contracted pharmacy timely and the medication is administered to the resident per the physician order daily Monday-Friday x 2 weeks, then 2 x weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1. Identified issues will be addressed immediately by the Quality Assurance Nurse. The Written Prescription Audit Tool will be used to complete the audit.</p> <p>The Director of Nursing will review and initial the audits weekly x 8 weeks, then monthly x 1 for trends and concerns.</p> <p>The results of the Written Prescription audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency of monitoring.</p>		

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F 309	Continued From page 19 PM with Nurse #5 who was working on 6/15/16. She stated she did not remember if Resident #309 had a hard prescription on admission. She stated if he did, she would make a copy of it for his chart. She reviewed the chart and did not find a copy of a prescription for Tylenol #4. She stated it was her practice to make a copy and then fax the orders to the pharmacy. She indicated after she had done that, she would move on to the next new admission. Resident #309 was interviewed a second time on 6/30/16 at 3:33 PM. He stated he was not given any information other than " the staff hadn ' t gotten an order for the Tylenol #4 ". He stated he had told several staff members he had pain but could not recall which ones. An interview was conducted 6/30/16 at 3:45 PM with the Director of Nursing (DON). She stated Resident #309 " did not come with a hard script. " She reported she had ordered the medication on Saturday, 6/25/16. She stated it was her expectation the nurse call the ordering physician for a written prescription. On 6/30/16 at 3:54 PM an attempt was made to reach Resident #309 ' s physician. He was unavailable. An interview was conducted on 6/30/16 at 5:00 PM with the Administrator. She stated it was her expectation for residents to receive their medications within 24 hours of admission. She added 11 days was too long to wait for a medication.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		7/28/16	

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F 315	<p>Continued From page 20</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to send a laboratory specimen to the laboratory for a diagnosis to initiate treatment for 1 of 1 residents (Resident # 125) reviewed for urinary tract infection. The findings included: Resident #125 was admitted to the facility on 2/3/2016 with diagnoses which included dementia. The Resident's quarterly Minimum Data Set (MDS) assessment dated 5/26/2016, revealed the resident's cognition was severely impaired. She needed extensive assistance for activities of daily living, and was always incontinent of bladder and bowel. A review of a physician order date 6/8/2016, specified obtain a urine sample for repeat UA (urinalysis), C &amp; S (culture and sensitivity), and may use straight catheter if needed. A nurse's note dated 6/9/2016 at 1:02 PM, revealed 2 attempts were made to obtain a urine specimen but were unsuccessful with 2 straight catheters. A nurse's note dated 6/10/2016 at 12:20 AM included the urine specimen was collected via straight catheter. Laboratory results were reviewed for urinalysis dated 6/14/2016 which indicated a UTI. Culture</p>	F 315	<p>F315</p> <p>The facility will ensure that a resident that is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections by ensuring that laboratory specimens are sent to the laboratory for analysis timely.</p> <p>The laboratory specimen was obtained from resident # 125 on 6/14/16 and sent to the lab. The resident was started on Rocephin 1 GM IM for UTI on 6/17/16 mixed with lidocaine given daily x 10 days per physician's orders.</p> <p>A 100% resident lab audit was completed by the ADON, MDS nurses and Unit Manager on 6/16/16-6/22/16 to ensure all ordered labs had been drawn timely, the physician was notified of the results, and any new orders had been carried out. All issues with the audit were corrected as identified. A new lab process was implemented on 6/16/16 to ensure labs are obtained, sent to the lab and any new orders are carried out timely.</p>		

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F 315	<p>Continued From page 21</p> <p>and sensitivity results dated 6/17/2016, revealed the urine contained Escherichia Coli greater than 100,000 colony-forming units per milliliter (CFU/ML), and Proteus Mirabilis greater than 100,000 CFU/ML.</p> <p>An interview was conducted on 6/29/2016 at 1:39 PM with Nurse #6. The nurse stated the order for the urine specimen appeared on the resident 's Medication Record Administration/Treatment Administration Record (MAR/TAR), on 6/8/2016. The nurse indicated she tried to obtain the specimen with a straight catheter at 2 different times during her shift, but was unable to obtain a specimen. She stated she passed on the information to the evening nurse when she came on duty, and that nurse was able to get the specimen. She indicated the specimen was placed in the refrigerator since it was collected after 11:00 PM, and for some reason, was not transported to the laboratory (lab) the next day. She indicated she did not know where the miscommunication occurred.</p> <p>On 6/29/2016 at 3:29 PM, an interview was conducted with Nurse #7. The nurse stated she obtained the urine specimen from the resident on 6/8/2016, but it was after 11:00 PM, and so she put the specimen in the refrigerator. The nurse indicated that since the specimen was not an urgent order, it was supposed to have been taken to the lab the following day. The nurse stated she had spoken to the resident's family on 6/7/2016 and had sent a fax to the doctor for the family's request for a urine specimen. The nurse stated the family said the resident was not acting normal, but the nurse did not know the resident, so she had no baseline on the resident's normal. The nurse stated she reviewed the resident's vital signs, and did not smell a urine odor when she assessed the resident, so she sent a request to</p>	F 315	<p>100% of licensed nurses will be re-educated by the Director of Nursing, Director of Clinical Operations, or the Unit Manager on the new lab protocol for the facility by 7/28/16. The new process is: When a nurse receives an order for a lab, the order for the lab is written on the lab calendar for the ordered date at the nurse station. The nurse will write noted on the order noting the order has been documented on the calendar. The lab requisition will be completed by nurse taking the order and placed in the binder at the nurse station for the lab company to use. Once the lab has been obtained, the resident's name is then hi-lighted in Yellow. Once the lab is signed by the physician and any new orders are carried out, the name will be hi-lighted in Blue. Labs not completed within 3 days should be followed up by the nurse, unit manager or Quality Assurance nurse to determine status of ordered lab.</p> <p>The Quality Assurance Nurse or Unit Manager will audit the lab calendars on the two nursing units (Cypress and Sycamore) 5 x weekly x 4 weeks then 3 x weekly x 4 weeks, then monthly x 1 to ensure the lab process is followed and that there are no lab orders that have not been reviewed by the physician that are more than 4 days old. The auditor will use the Lab Completion Audit Tool to complete the audit.</p> <p>The results of the audits will be reviewed and initialed by the Director of Nursing weekly x 8 weeks, then monthly x 1.</p>		

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F 315	Continued From page 22 the doctor for the urine specimen. The nurse stated she had been unaware the specimen had not been picked up by the lab. An interview was conducted with the Director of Nursing (DON) on 6/29/2016 at 4:06 PM. The DON stated the urine specimen was collected as ordered, however, it wasn't picked up so it had to be redone. She indicated the specimen was recollected and sent on 6/14/2016. On 6/30/2016 at 4:14 PM, an interview was conducted with the Administrator. The Administrator stated the specimen had not been picked up by the transporter the day after it was collected. She indicated that since the incident, their process had changed and the lab transporter was responsible to check the refrigerator every time he came.	F 315	The Executive Quality Assurance Team will review the results of the Audits monthly x 3 to determine the continued need and frequency of monitoring.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329		7/28/16	

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F 329	<p>Continued From page 23</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and pharmacist interviews and record review, the facility failed to discontinue a medication as ordered by a physician for 1 of 5 residents (Resident #211) reviewed for unnecessary medications which resulted in the resident receiving 2 antipsychotic medications for 6 days. Findings included: Resident #211 was admitted to the facility 9/25/15 with diagnoses which included dementia, depression, and psychotic disorder. Her quarterly Minimum Data Set of 6/1/16 indicated she was severely cognitively impaired. She was noted to have fluctuating behaviors of inattention and disorganized thinking. She exhibited wandering behavior 1-3 days during the assessment period. She was receiving antipsychotic medication 7 out of 7 days during the assessment period. A review of the June 2016 orders revealed an order dated and signed 6/1/16 to discontinue Risperdal (antipsychotic medication) and begin Seroquel 25 mg (milligrams) (antipsychotic medication) by mouth three times a day with the last dose being at bedtime. A review of the June 2016 Medication Administration Record (MAR) revealed Risperdal 1 mg by mouth given at noon 6/2/16 through 6/6/16. The MAR also revealed Seroquel 25 mg</p>	F 329	<p>F329</p> <p>Resident #211's order for Risperdal 1mg at noon was discontinued on 6/7/16 per physician's orders by Nurse #6.</p> <p>A 100% audit of all physicians' orders for medication changes from 1/1/16 through 6/23/16 was completed by MDS nurses x 3, the Unit Manager, and the Assistant Director of Nursing 6/16/16 through 6/23/16 to assure orders are transcribed correctly. All identified concerns were reviewed with the physician.</p> <p>Nurse #2 was re-educated on discontinuing a medication on 7/27/16 by the Director of Nursing .</p> <p>100% of licensed nurses will receive re-education for transcribing physician's orders by the Director of Clinical Operations, the Director of Nursing, or Staff Development Coordinator by 7/28/16.</p> <p>The Quality Assurance Nurse will review all new physicians' orders to assure all orders were transcribed correctly utilizing</p>		



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F 329	<p>Continued From page 24</p> <p>by mouth given at 9:00 AM, 2:00 PM, and 9:00 PM.</p> <p>A review of the psychiatric progress note on 6/7/16 showed the physician noted " the resident was still receiving both Seroquel and Risperdal. I thought I had written an order to discontinue Risperdal at my last visit. I do see an order from primary care to discontinue risperidone. " Further review of the orders revealed an order written and signed by the psychiatric physician on 6/7/16 to discontinue Risperdal if not already done.</p> <p>An interview was conducted 6/29/16 at 11:25 AM with Nurse #1. She stated when written or verbal orders are received, the nurse taking them is responsible for sending a copy to the pharmacy, calling the responsible party to notify them of a new order, and entering the new order in the computer system. She stated if the order is received late in the shift, it may be passed on to the next shift ' s staff.</p> <p>A review of the medication entry screen revealed the Risperdal 1 mg at bed time was discontinued by Nurse #2 at 11:30 PM on 6/1/16. The Risperdal 1 mg at noon was discontinued on 6/7/16 by Nurse #6.</p> <p>An interview was conducted 6/29/16 at 11:45 AM with the Director of Nursing (DON). She stated the nurses are responsible for processing orders by discontinuing the medications as written and entering the new medications into the computer system. The nurse makes a copy of the written order and gives it to the administrative staff for review the next morning. She stated herself and the Assistant Director of Nursing (ADON) review the copies. She stated " we didn ' t see there were 2 doses. "</p> <p>An interview was conducted 6/29/16 with the Administrator. She stated it was her expectation</p>	F 329	<p>a Clinical Review Meeting QI Tool. Monitoring will occur daily Monday- Friday x 4 weeks, then 2 x per week x 4 weeks, then monthly x 1.</p> <p>The Director of Nursing will review and initial the audits weekly x 8 weeks, then monthly x 1 month.</p> <p>The results of the audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 months to determine the need and frequency for continued monitoring.</p>		

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F 329	Continued From page 25 that medications would be discontinued when the order was written. She stated the 11 PM to 7 AM nurse was responsible for checking the orders with her nightly chart checks. She further stated that the facility had put a new step in place of getting copies of new orders and having the DON and ADON review them for accuracy. She stated the facility had identified some issues with medication errors and had put a plan of correction in place which was dated 6/7/16 with an in-service conducted 6/8/16. In a later interview at 1:18 PM, she stated the facility had begun the plan of correction based on multiple examples of medication error issues. She stated the medication error for Resident #211 was not one of those errors that triggered the action plan. An interview was conducted 6/29/16 at 4:30 PM with Nurse #2. She stated that she did not realize each dose of Risperdal 1 mg was entered separately so she did not know she had to discontinue each dosage separately. She stated she would double check from now on when she discontinued medications. An interview was conducted 6/30/16 at 9:03 AM with the facility pharmacy consultant. She stated the resident was monitored for disknetic symptoms and sedation and none had been documented so she did not have any concerns regarding the medication error.	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353		7/28/16	

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F 353	<p>Continued From page 26</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff, resident and family interviews and review of records, the facility failed to provide sufficient staff to take care of residents needs.</p> <p>Findings included:</p> <p>Review of the resident council minutes revealed members had complained of slow call light response, staffing issues and/or slow meal delivery in March, April, May and June 2016.</p> <p>During the initial tour of the facility, held on 6/27/16 starting at 11:00 AM, multiple residents were observed in facility gowns. Beds on all halls were seen unmade.</p> <p>An interview was held with the family of Resident #69 on 6/27/16 at 4:07 PM. The family member stated staffing was short and on the weekends, it</p>	F 353	<p>F353</p> <p>Resident #132 was discharged 7/1/2016.</p> <p>Resident #307 was discharged 7/3/16.</p> <p>Resident #139 was discharged on 7/24/16</p> <p>Resident #154 was interviewed by Social Worker on 7/23/16 and he stated that he felt response to his call bell had improved</p> <p>Resident #131 was interviewed on 7/26/16 by the Social Worker and states call bell response is improved and has not soiled herself due to slow call bell response.</p> <p>Resident # 33 was re-interviewed on 7/26/16 and stated he had no concerns he</p>		

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F 353	<p>Continued From page 27</p> <p>was hard to get help. The family member added when staff failed to respond to call lights, they would go find someone to help Resident #69.</p> <p>An interview with Resident #132 was held on 6/27/16 at 4:59 PM. The resident stated staffing was short, but stated poor staffing was not isolated to one shift. She stated staff seemed to always be in a hurry and always rushed when they came in to help. The resident stated while waiting for staff to assist with toileting this morning, she had wet herself.</p> <p>Resident #307 was interviewed on 6/27/16 at 5:27 PM. Resident #307 stated when she was first admitted she was instructed not to get up alone. She added she used her call bell when assistance was needed, but after waiting at least 30 minutes, she would get up alone. Resident #307 stated she would rather take a chance getting up alone than wet herself.</p> <p>On 6/28/16 at 8:46 AM, Resident #131 was interviewed. She stated staffing was not good and added night shift was the worse. The resident stated she had waited well over an hour for call bells to be answered.</p> <p>During an interview with Resident #139 on 6/28/16 at 9:06 AM, she stated staffing was not good in the facility and worse on weekends. The resident added she had soiled herself while waiting for staff to assist her to the toilet.</p> <p>At 9:42 AM on 6/28/16, Resident #33 was interviewed. The resident stated there was not enough staff in the facility. He added he had noticed a change after the new company took over; adding there was less staff and longer wait</p>	F 353	<p>wants addressed at time.</p> <p>Roommate of #33-was interviewed by the Social Worker on 7/26/16 and stated he had no concerns. States he is gotten up by the staff when he wants to be up and goes to activities when he wants to go.</p> <p>The Administrator signed a contract with Steadfast Staffing Solutions staffing agency on 8/1/16 to assure staffing needs for licensed nurses and nursing assistants are met. The Administrator is offering sign on bonuses for licensed nurses and certified nursing assistants until staffing is sufficient to meet resident needs. The Administrator is offering shift bonuses for licensed nurses and certified aides for all shifts as an incentive for part-time and PRN staff to work additional shifts as the need arises. The Administrator and Director of Nursing have implemented the above listed measures to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The Administrator, Assistant Administrator, Social Worker and Activity Director will be inserviced by the Director of Clinical Operations that resident concerns voiced in or outside of Resident Council or Resident Interview should be addressed through the Resident Concern Process and resolved promptly to include prompt notification of the resident</p>		

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F 353	<p>Continued From page 28</p> <p>times. Resident #33 stated previously he had received his bath before 11:00 AM and now it was after 11:00 AM and sometimes after lunch. The resident added he had noticed his room mate was missing activities because he was not bathed, dressed and ready.</p> <p>Resident # 154 was interviewed on 6/28/16 at 5:50 PM. The resident stated at times he was left on the bedpan for 45 minutes to an hour. He stated he knew it was that long because he could look at the clock hanging in his room. The resident stated it was mostly the 3-11 shift and had happened most recently over the weekend. The resident stated at other times, the staff would come in, turn the light off and come back when they felt like it, without answering his need. At 5:55 PM, the call light was turned on by Resident #154. While sitting in the wheelchair, voices could be heard passing the room, and shadows of feet were seen passing the door without stopping. The resident stated it was normal for staff to pass, but not stop to see what was needed. At 6:05 PM, the call light was answered.. The resident stated while the surveyors were in the building, his light had been answered more quickly.</p> <p>Resident #33 was interviewed on 6/30/16 at 10:30 AM. The resident remained in bed. Resident #33 added that on 6/29/16 it was after 11:00 AM before he was bathed, dressed and transferred to his wheelchair. He stated since the change in facility ownership, the number of staff had been reduced and it was much later when he received his morning bath and was able to get out of bed. On 6/30/16 at 12:15 pm, the resident's bath had been completed and he was observed being transferred to his wheelchair by Nursing</p>	F 353	<p>regarding resolution of the voiced concern.</p> <p>The Social Worker, Assistant Administrator and Activities Director will interview 10 alert and oriented residents weekly x 4 weeks, then every two weeks x 1 month, then monthly x 1, that did not attend Resident Council to include resident #33, #131 and #154 to determine if residents feel improvement has been made in meeting resident needs by facility staff. The Resident/Family Staffing Questionnaire Audit Tool will be used. Concerns will be addressed through the Resident Concern Process. A Resident Concern Form and Concern Log will be used.</p> <p>The Social Worker, Assistant Administrator and Activities Director will interview 2 family members weekly x 4 weeks, then every two weeks x 1 month, then monthly x 1 to determine if families feel improvement has been made in meeting resident needs by facility staff. The Resident/Family Staffing Questionnaire Audit Tool will be used. Concerns will be addressed through the Resident Concern Process. A Resident Concern Form and Concern Log will be used.</p> <p>The Activity Director will request a special Resident Council meeting on 7/27/16 to request resident council meet weekly x 4 weeks, then 2 x monthly x 1 month, then monthly x 1. The Activity Director and Social Worker will use the</p>		

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F 353	<p>Continued From page 29 Assistant (NA) #3.</p> <p>Nurse #10 was interviewed on 6/30/16 at 2:05 PM. She stated there was not enough nurses or NAs in the facility. The nurse added there were several nurses who were working 70 or more hours per week. She stated in addition to giving medications, doing treatments, the nurses were also having to assist the NAs with bathing and dressing of residents and providing incontinent care. She stated NAs were only able to turn and position residents every 4-5 hours adding that weekends were even worse and the 3-11 shift was the worse. The nurse added staff had verbalized their concerns to administration and were assured things would "get better". Nurse #10 added that administrative staff did not typically help pass trays during meals or assist with feeding residents and that had been something only done during the survey. She added there was one administrative person out on the halls Monday that she had not seen before and had actually thought for a moment she was a surveyor.</p> <p>On 6/30/16 at 2:23 PM, NA #3 was interviewed. She acknowledged Resident # 33 required assistance with bathing, dressing and transfer. The NA stated when she worked she typically had an average of 11 to 13 residents. She stated she got any residents with appointments up first and assisted the other residents as she got to them. The NA stated her ability to check for incontinence and turn and position residents depended on the number of residents she was assigned. NA #3 stated when assigned 13 residents she provided incontinent care when she provided their bath and then provided incontinent care one more time before going home. Turing</p>	F 353	<p>Resident/Family Staffing Questionnaire Audit Tool and record resident council minutes at each meeting to determine if residents feel improvement has been made in meeting resident needs by facility staff. Concerns will be addressed through the Resident Concern Process. A Resident Concern Form and Concern Log will be used.</p> <p>The results of the Questionnaires and Resident Concern Log will be reviewed and initialed by the Administrator weekly x 4, then 2 x monthly x 1 month, then monthly x 1 to assure resident needs are met by facility staff and Resident Concerns voiced in and outside of Resident Council are resolved timely.</p> <p>The results of the Questionnaires and Resident Concern Log will be reviewed by the Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency for monitoring.</p>		

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F 353	<p>Continued From page 30</p> <p>and positioning was done at the same time; usually every 3-4 hours. The NA stated she felt the facility was absolutely short staffed which made it almost impossible to bathe, feed residents, provide incontinent care and turn and position as the residents required. The NA stated sometimes it was 1:30 PM before she completed bathing residents and they did complain. She added Resident #5 was her fifth bath today and she had 6 more baths to give before she went home. The NA stated she had only provided incontinent care and turning and positioning twice today or every 4 hours; once before lunch and once prior to going home. NA #3 stated she had been surprised to see the administrative staff help pass trays and feed residents since the survey team had been in the building.</p> <p>The Activity Director was interviewed on 6/30/16 at 2:47 PM. She stated she was responsible for assisting residents in organizing the resident council meetings. The AD stated if residents voiced concerns as a group, then the concern was written as a resident council concern. If it was one person that voiced the concern, the concern was written on a grievance form and was not discussed as old business during the next meeting. She reviewed the resident council minutes and acknowledged several residents had concerns about staffing, meals sitting on the tray cart for extended periods of time and served cold, long call bell response time. Those concerns are then given to the Administrator who assigns a department to investigate. She was unsure of the outcome of the personal grievances.</p> <p>NA #6 was interviewed on 6/30/16 3:32 PM. The NA stated while while assigned 12 residents on the current shift, the usual work load for the 3-11</p>	F 353			

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F 353	<p>Continued From page 31</p> <p>shift was 14 to 16 residents. The NA added some residents took almost an hour to get ready for bed, which made completing work difficult. The NA added checking for incontinence and turning and positioning residents every 2 hours was impossible and most of the time only 2 incontinent checks per shift were completed. The NA acknowledged there was not enough staff to pass the dinner meal and assist residents with their meal and therefore, some residents received cold food. The problem had been relayed to administration and staff were told administration would do something; but the NA added nothing was ever done.</p> <p>On 6/30/16 at 3:47 PM, NA #7 was interviewed. The NA stated recently staff had been cut. Most of the time, the NA stated the usual work load was 15 residents. The NA stated it was virtually impossible to get all residents fed timely and provide incontinence rounds every 2 hours. At times, everyone has not been fed until 7:30 PM.</p> <p>Nurse #4 was interviewed on 6/30/16 at 4:04 PM. She stated staffing had been horrible since the new company took over. NAs on each unit had been decreased from 4 NAs to 3 and sometimes the unit would only have 2 NAs. The nurse stated while staff did the best they could, she was sure incontinent rounds were not being made as needed.</p> <p>The Director of Nursing (DON) was interviewed on 6/30/16 at 4:29 PM. The DON reviewed the staffing pattern before and after the facility transitioned from one company to another and acknowledged there had been a decrease in staffing. The DON stated she thought the reports from residents, families and staff were</p>	F 353			



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F 353	Continued From page 32 due to disgruntled employees talking about the changes in staffing to residents.	F 353			
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON  Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to prevent the Director of Nursing from working as a staff nurse. The findings included: The Centers for Medicare and Medicaid Services (CMS) website revealed the facility 's total number of certified and licensed beds was 146. An interview was conducted with the Director of Nursing (DON) on 6/30/2016 at 2:36 PM. The DON stated she only served as a charge nurse when a nurse called out sick and couldn't be replaced. She stated the last time this occurred was 6/25/2016 on the 3:00 PM to 11:00 PM shift. The DON stated she passed medications on that shift, as each medication nurse was in charge of the residents on their respective units.	F 354	F354 The Director of Nursing has not worked in the capacity of a charge nurse since 6/25/16.  The Director of Clinical Operations inserviced the Administrator and the Director of Nursing on 7/27/16 that the Director of Nursing is not to work in the capacity of a charge nurse.  The Administrator signed a contract with Steadfast Staffing Solutions staffing agency on 8/1/16 to assure staffing needs for licensed nurses and nursing assistants are met. The Administrator is offering	7/28/16	

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F 354	Continued From page 33 The Administrator and DON were interviewed on 6/30/16 at 5:00 PM. They acknowledged the DON had acted as charge nurse during off hours and on weekends. The Administrator stated since it was off hours, meaning nights or weekends, she thought it was ok for the DON to work the hall and pass medications.	F 354	sign on bonuses for licensed nurses and certified nursing assistants until staffing is sufficient to meet resident needs. The Administrator is offering shift bonuses for licensed nurses and certified aides for all shifts as an incentive for part-time and PRN staff to work additional shifts as the need arises. The Administrator and Director of Nursing have implemented the above listed measures to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The Administrator will review and initial the daily assignment sheets weekly x 12 weeks to assure the Director of Nursing has not worked in the capacity of a charge nurse.  The results of the audit will be reviewed by Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency for monitoring.		
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	F 431		7/28/16	

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F 431	<p>Continued From page 34 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to label and date open vials of Purified Protein Derivative (PPD) used to determine if a person has tuberculosis in 2 of 2 medication refrigerators.</p> <p>Findings included:  Review of the facility policy on Expiration of Opened Multi-Dose Vials, revised on 1/1/14,</p>	F 431	<p>F431</p> <p>The 5 vials of PPD solution were discarded on 6/28/16 by the charge nurse present during the observations with the state agent.</p> <p>100% medication room audit was completed on 6/28/16 by the four MDS nurses to assure all medication had not</p>		

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F 431	<p>Continued From page 35</p> <p>indicated all multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time the seal is broken and the first dose drawn. The policy further indicated PPD was good for 30 days after the vial had been opened.</p> <p>On 6/28/16 at 2:20 PM, the medication refrigerator on the facility's Sycamore unit was observed and yielded one multi-dose vial of PPD that had been opened and not dated. At this time, Nurse #8 was interviewed. She stated the nurse that opened the vial was responsible for dating the vial. Nurse #8 added without a date on the opened vial, it was uncertain if the PPD was within the 30 day open limit.</p> <p>During an observation of the Cypress Unit medication refrigerator on 6/28/16 at 2:25 PM, 4 vials of opened PPD were discovered. The 4 vials had no date that represented when they had been opened. Nurse #9 was interviewed at that time and acknowledged there was no date on the vials. She stated the nurse that opened the vial was responsible for dating the vial. Nurse #9 added without the open date, the effectiveness of the PPD was unable to be determined.</p> <p>The Director of Nursing (DON) was interviewed on 6/29/16 at 2:51 PM. The DON stated all medication vials were to be dated by the nurse that opened the vial. She stated the Unit Managers were also responsible for removing any expired medications or undated medications from the unit medication refrigerators.</p>	F 431	<p>passed their expiration date and all opened vials were dated when opened and had not expired. No concerns were identified during the audit.</p> <p>100% inservice of all licensed nurses was initiated on 6/29/16 by the Staff Development Coordinator and Director of Clinical Operations to check the expiration date before administering any medication and dating all vials when first opened. Newly hired licensed nurses will receive the inservice during orientation.</p> <p>Utilizing the Expired Medication Audit Tool the Unit Manager, Weekend Supervisor and Staff Development Coordinator will check both medication rooms daily x 14 days, then 5 x weekly x 2 weeks, then weekly x 4, then monthly x 1 to ensure no expired medication is in use</p> <p>The DON will review and initial the audit tool weekly x 8 weeks, then monthly x 1 for trends and concerns</p> <p>The results of the audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 to determine continued need and frequency for monitoring.</p>		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		7/28/16	

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F 441	<p>Continued From page 36</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441			

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F 441	<p>Continued From page 37</p> <p>Based on observations, staff interviews and record review, 1 of 4 nursing assistants (Nursing Assistant #9) failed to wash hands after touching a urinal and before returning to the tray cart to complete passing lunch trays.</p> <p>Findings included:</p> <p>The facility 's policy on hand-washing, revised in August 2014, indicated the facility considered hand hygiene the primary means in preventing the spread of infection. The policy further indicated either hand-washing or the use of an alcohol based hand rub should be used before and after direct contact with residents, after contact with objects in the immediate vicinity of the resident, before and after assisting a resident with meals and after handling contaminated equipment.</p> <p>An observation was made on 6/27/16 at 12:55 PM. Nursing Assistant (NA) # 9 removed a tray from the lunch tray cart and walked toward Resident # 276 ' s room. Upon entering the room, she removed the resident ' s urinal from the over bed table and placed his lunch tray on the table. After touching the urinal NA #9 did not wash her hands before opening the resident ' s meal, beverages and silverware. She left Resident #276 ' s room, returned to the tray cart and removed the lunch tray for Resident #7. NA #9 proceeded to Resident #7 ' s room and placed the resident ' s lunch tray on her over bed table. Again, without washing her hands, NA #9 returned to the tray cart to serve other resident ' s their lunch.</p> <p>At 12:59 PM on 6/27/16, NA #9 was interviewed. The NA acknowledged she had touched Resident</p>	F 441	<p>F441</p> <p>Resident #276 was not being treated with an antibiotic for an infection during the time of the observation of 6/27/16.</p> <p>NA #9 was reeducated on proper hand washing and infection control on 6/ 29 /16 by the Staff Development Coordinator.</p> <p>100 % of facility staff received reeducation of the facility policy on Hand Washing and Hygiene to include equipment and supplies, washing hands, use of Alcohol based hand rubs, and applying and removing gloves by the Staff Development Coordinator and the Director of Clinical Operations beginning 6/29/16.</p> <p>Utilizing the Meal Pass Sanitation Observation Audit Tool the Staff Development Coordinator, Quality Assurance Nurse, Assistant Administrator, Social Service Department and Unit Manager will monitor hand hygiene of staff while passing meal trays 3 meals daily x 14 days, then Monday- <input type="checkbox"/> Friday x 2 weeks, then weekly x 4 weeks, then monthly x 1</p> <p>The Director of Nursing will review and initial the audits weekly x 8, then monthly x 1 for trends and concerns.</p> <p>The results of the audits will be presented to the Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency for monitoring.</p>		

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F 441	Continued From page 38 #276 ' s urinal and had not washed her hands before preparing his meal. She stated she had not washed her hands before leaving Resident #276 ' s room, returning to the tray cart and serving Resident #7 her lunch. The NA stated she had been taught to wash her hands between dirty and clean tasks. The NA could give no explanation why she had not washed her hands after moving the urinal and prior to preparing the resident ' s meal and prior to returning to the tray cart to serve other residents.  The Director of Nursing (DON) was interviewed on 6/29/16 at 2:47 PM. She stated she expected the staff to wash their hands between dirty and clean tasks. The DON added she considered handling a urinal a dirty task and NA #9 should have washed her hands before preparing the resident ' s lunch and before returning to the tray cart to pass other resident ' s their lunch.	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		7/28/16	

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NAME OF PROVIDER OR SUPPLIER  <b>ELIZABETH CITY HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909</b>		
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F 520	<p>Continued From page 39</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitoring practices to address interventions put into effect after the 8/20/15 recertification survey. During the survey of 8/20/15 the facility was cited at F279 for failure to develop a care plan with measureable goals for monitoring side effects of antipsychotics for a resident receiving antipsychotic medications and at F315 for failure to provide a diagnoses to justify the use of an indwelling urinary catheter. During the Recertification survey of 6/30/16, the facility was recited at F279 for failure to develop a care plan to address hospice and end of life issues and at F315 for failure to send a laboratory specimen to the laboratory for a diagnosis to initiate treatment for a urinary tract infection. The continued failure of the facility during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance program.</p> <p>The findings included: This tag is cross referenced to: 1a. F279: Develop Comprehensive Care Plans. Based on staff interviews and record review, the</p>	F 520	<p>F520</p> <p>The care plan for Resident #275 was revised by the MDS nurse on 6/30/16 to reflect the resident's end of life wishes and hospice services. However, new orders were received 7/15/16 to discontinue Hospice services, and the care plan for hospice services was discontinued by the MDS Nurse on 7/16/16.</p> <p>A 100 % audit of all resident's most recent care plans was completed by the company contracted MDS nurse, Quality Assurance Nurse and ADON on 7/23/16 to assure resident care plans accurately reflect the resident based on resident needs and condition to include hospice services and medications. Issues were corrected as identified.</p> <p>The four MDS nurses completed the Review of the RAI Manual by 7/20/16 to include the care planning process.</p>		



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F 520	<p>Continued From page 40</p> <p>facility failed to develop a care plan to address hospice and end of life issues for 1 of 1 sampled resident (Resident #275) reviewed for hospice services.</p> <p>During the recertification survey of 8/20/15, the facility was cited at F279 for failure to develop a care plan with measureable goals of monitoring for the side effects of antipsychotic medication use for 1 of 5 residents (Resident #39) reviewed for unnecessary medication usage who was receiving antipsychotic medications. On the current survey of 6/30/16, the facility failed to develop a care plan to address hospice and end of life issues for 1 of 1 sampled resident (Resident #275) reviewed for hospice services.</p> <p>1b. F315: Prevent Urinary Tract Infections. Based on observation, record review, and staff interviews, the facility failed to send a laboratory specimen to the laboratory for a diagnosis to initiate treatment for 1 of 1 residents (Resident #125) reviewed for urinary tract infection.</p> <p>During the recertification survey of 8/20/15, the facility was cited at F315 for failure to provide a diagnosis to justify the use of an indwelling urinary catheter for 1 or 2 residents reviewed (resident #56). On the current survey of 6/30/16, the facility failed to send a laboratory specimen to the laboratory for a diagnosis to initiate treatment for 1 of 1 residents (Resident #125) reviewed for urinary tract infection.</p> <p>On 6/30/16 at 5:00 PM, an interview was conducted with the Administrator. She stated that the Quality Assessment and Assurance (QA &amp; A) Committee was comprised of the Administrator, Assistant Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing and all department managers, unit managers and Pharmacy Consultant. She stated it was the expectation of the managing company that the</p>	F 520	<p>The Quality Assurance Nurse will review 2 random resident care plans weekly x 12 weeks to ensure the care plan accurately reflects the resident based on resident needs and condition to include hospice services and medications . The Care Plan Audit Tool will be used.</p> <p>The Director of nursing will review and initial the audits weekly x 12 weeks for trends and concerns.</p> <p>The results of the care plan audits will be reviewed by the Executive Quality Assurance Committee monthly x 3 to determine the continued need and frequency of monitoring.</p> <p>A 100 % audit of all residents with orders for indwelling catheters was completed by the Assistant Director of Nursing on 7/21/16 to ensure all residents with indwelling catheters have a supporting diagnosis for the use of the indwelling catheter. An Indwelling Catheter Audit Tool was used. Concerns identified were corrected by the Assistant Director of Nursing in collaboration with the physician.</p> <p>The Quality Assurance nurse will audit residents with indwelling catheters monthly ongoing to ensure an indwelling catheter has medical justification for indwelling catheter use. An Indwelling Catheter Audit Tool will be used. Trends and concerns will be addressed as identified.</p>		

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F 520	Continued From page 41 QA & A Committee meet monthly. She identified areas that had been discussed in weekly at risks meetings which included monitoring of weights, wounds, falls and incidents, Wanderguards (alarms for residents at risk for elopement), nutritional supplements, and Medical Director/Responsible Party notification for wounds. She further stated the last QA & A meeting was held in May 2016 however she was away from the facility at that time. She stated the next scheduled meeting was for today, 6/30/16 and that would be rescheduled to July. She was not aware of any current audits or measures regarding urinary tract infections or to ensure care planning accuracy since she joined the facility in April, 2016. The Director of Nursing was interviewed at the same time and stated the facility had monitored care planning and reported to the QA & A Committee after the recertification survey of 8/20/15 but she was not aware of any current auditing tools in place. She did not indicate there were any current auditing tools in place for urinary tract infection monitoring.	F 520	The Director of nursing will review and initial the Indwelling Cather Audit Tool monthly x 3 for trends and concerns.  The Executive Quality Assurance Committee will review the results of the audit monthly x 3, then no less than quarterly for trends and concerns.  The laboratory specimen was obtained from resident # 125 on 6/14/16 and sent to the lab. The resident was started on Rocephin 1 GM IM for UTI on 6/17/16 mixed with lidocaine given daily x 10 days per physician's orders.  A 100% resident lab audit was completed by the ADON, MDS nurses and Resident Care Coordinator on 6/16/16-6/22/16 to ensure all ordered labs had been drawn timely, the physician was notified of the results, and any new orders had been carried out. All issues with the audit were corrected as identified. A new lab process was implemented on 6/16/16 to ensure labs are obtained, sent to the lab and any new orders are carried out timely.  100% of licensed nurses were re-educated by the Director of Nursing, Director of Clinical Operations, or the Unit Manager on the new lab protocol for the facility by 7/28/16. The new process is: When a nurse receives an order for a lab, the order for the lab is written on the lab calendar for the ordered date at the nurse station. The nurse will write noted on the order noting the order has been documented on the calendar. The lab		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 42	F 520	<p>requisition will be completed by nurse taking the order and placed in the binder at the nurse station for the lab company to use. Once the lab has been obtained, the resident's name is then hi-lighted in Yellow. Once the lab is signed by the physician and any new orders are carried out, the name will be hi-lighted in Blue. Labs not completed within 3 days should be have follow up by the nurse, unit manager or Quality Assurance nurse to determine status of ordered lab.</p> <p>The Quality Assurance Nurse or Unit Manager will use the Lab Completion Audit Tool to audit the lab calendars on the two nursing units (Cypress and Sycamore) 5 x weekly x 4 weeks then 3 x weekly x 4 weeks, then monthly ongoing to ensure the lab process is followed and that lab orders are carried out timely per physician order.</p> <p>The results of the lab audits will be reviewed and initialed by the Director of Nursing weekly x 8 weeks, then monthly x 1.</p> <p>The Executive Quality Assurance Team will review the results of the Lab Audits monthly x 3, then no less than quarterly for trends and concerns.</p>		