| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345109 | A. BUILDING _____ B. WING _____ | C 07/20/2016 |

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| **TRINITY PLACE** | **24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a recertification and complaint investigation survey on 7/11/16. During the survey, it was determined the facility had provided substandard quality of care at the Immediate Jeopardy level. A partial extended survey was conducted and an exit conference was held with the facility on 7/14/16. The Immediate Jeopardy began on 7/10/16 and was removed on 7/14/16.<br>Additional information were obtained on 7/20/16 to complete the survey. Therefore, the exit date was changed from 7/14/16 to 7/20/16<br>On 8/9/16, the statement of deficiencies was amended. Example #2 regarding Resident #84 was deleted by the survey team. | F 000 | | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). | F 157 | | 8/15/16 |

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

Electronically Signed | 08/10/2016

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| F 157 | Continued From page 1<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to notify the nurse practitioner as ordered for one of one residents (Resident #62). The findings included:<br><br>Resident #62 was admitted to the facility 10/3/12 and last readmitted on 4/25/14. Cumulative diagnoses included: atrial fibrillation, diabetes and Parkinson's disease.<br>A Quarterly Minimum Data Set dated 6/22/16 indicated she was moderately impaired in cognition.<br>A nursing note dated 7/11/16 at 2:28AM stated "observed on mat next to bed. Resident observed laying on stomach with neck stuck in between bed rail and bed, body straight out half on bed, half off bed, legs straight out touching the floor mat, arms at side. Bed was in low position. Floor mat was down. Upon resident being put back to bed, full assessment and skin assessment was completed. Signs and symptoms of pain were presented when the | F 157 | PLAN OF CORRECTION: 483.10 F157<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br>For all residents and families affected:<br>On 7/11/16 at 1:30 pm the Nurse Practitioner was notified of an incident that occurred on 7/10/16 at approximately 9:40 pm for resident #62. The on-call physician was also notified of the incident on the night of 7/10/16 at 10:56 pm, and then again in the early morning of 7/11/16.<br>For all residents that have the potential to | |

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| F 157 | Continued From page 2<br>anterior left side of neck was palpated. No swelling, redness or bruising was noted." The Physician on call was called and new orders were received. The time of incident was documented as follows: 7/10/16 at 9:40PM. The equipment involved was documented as bed rails.<br><br>An x-ray of the cervical spine dated 7/10/16 indicated the following: Impression linear lucency within the anterior aspect of the C4 vertebral body, consistent with a fracture.<br><br>A nursing note dated 7/11/16 at 2:43 AM stated the on-call physician was notified of the results. The on-call physician stated for the in house physician to see resident in the morning and for resident to see orthopedic physician.<br><br>Medical record review revealed a physician's order dated 7/11/16 that stated to get an appointment for resident to see orthopedic physician and resident to see in house physician in the morning on 7/11/16.<br>On 7/11/16 at 1:45PM, Resident #62 was seen by the Nurse Practitioner and orders were given to send Resident #62 to the hospital emergency room for evaluation and for a computerized tomography (CT) scan of the cervical spine.<br><br>A CT scan of the cervical spine without contrast dated 7/11/16 stated the following: Findings: Normal alignment. No evidence of fracture. There is multilevel cervical spondylosis (neck arthritis) with posterior disc osteophyte (bone spur) complexes and bilateral facet hypertrophy (degeneration and enlargement of joints). Impression: cervical spondylosis without evidence of cervical fracture or malalignment. | F 157 | be affected:<br>On 7/11/16, the Medical Records Director reviewed physician orders from the previous 24 hours to ensure that all physician orders were carried out. No other residents were affected. However, because all residents have the potential to be affected, all licensed nurses were in-serviced/re-educated by the Staff Development Coordinator (SDC), Minimum Date Set (MDS) nurses or Director of Nursing (DON) on facility's guidelines and procedures for following physicians orders and notifying resident's physician, legal representative or interested family member for an injury, decline in condition, room change, etc., including the facility policy titled "Physician's Orders". This training was completed by 8/03/2016. Nurses who were unable to be reached by phone or attend in-service will be in-serviced prior to their next scheduled shift.<br>The policy titled, "Physician's Orders" is available for all-staff at all times on the facility's online portal.<br>Measures put in place to ensure deficient practice will not reoccur:<br>Effective 8/04/16, a "reminder" button was added to our electronic medical records system. This will allow the nurse to send an alert to the first shift supervisor and first shift nurse that the physician needs to be notified by the first shift nurse. All licensed nurses and medication aides will be in-serviced on this process by 8/15/16. All licensed nurses and medications aides who cannot be reached in person or via phone will be in-serviced prior to their next | |

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| F 157 | Continued From page 3<br>On 7/14/16 at 11:23AM, an interview was conducted with the Nurse Practitioner. She stated she arrived at the facility around 12:15 or 12:30PM. She stated it was about one hour after that (1:30PM) when she was informed about Resident #62's incident that had occurred on 7/10/16, the positioning of Resident #62 at the time of the incident and that the on-call physician was called. She said she reviewed the x-ray results, examined Resident #62 around 1:45PM and ordered her to go to the hospital for a computerized tomography (CT) scan. The Nurse Practitioner stated if the facility had called her first thing in the morning (7/11/16) and read the x-ray results to her, she would have ordered a CT scan. If the CT scan could not have been done within an hour, she would have ordered for the facility to send Resident #62 to the emergency room via ambulance.<br>On 7/14/16 at 1:55PM, an interview was conducted with Nurse #4. He stated when he came on duty the morning of 7/11/16, he was told by Nurse #1 about the incident involving Resident #62. He stated Nurse #1 told him that she had notified the on-call physician and he had given her an order to get an orthopedic consult and for the nurse practitioner to see her the next day. Nurse #4 said he saw Resident #62's x-ray that stated the findings were consistent with a cervical fracture at C4. Nurse #4 stated he felt like the provider had already been made aware when the on call physician was notified of the results. Orders had been given by the on call physician the facility had done what he had ordered.<br><br>On 07/14/2016 at 2:23PM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to follow the physician's order and the Nurse Practitioner | F 157 | working shift. The first shift supervisor will be responsible for following-up with the first shift nurse that same day. There is a first shift supervisor seven days a week. In addition, the Medical Records Director or the Resident Care Coordinator will use an Order Audit form, noting if there was physician contact for each order that was received the previous day. If a physician has not been contacted, the auditor is to report to Director of Nursing immediately.<br>On July 12th, 2016, the nurse who was working when the incident occurred with resident #62 and the nurse who was working the following shift were both in-serviced by the Director of Nursing on the protocol for contacting the physician and following doctor's orders.<br>Monitoring plan to ensure solutions are sustained:<br>The Medical Records Director or Resident Care Coordinator will audit, using an established check Order Audit sheet, five residents chosen randomly from our electronic medical records system, to verify that physician's orders have been recorded and carried out correctly for any orders the occurred in the last seven days for the chosen resident, including contact a physician if required. This audit will occur two times weekly for one year to ensure physician was contacted when required.<br>The results of these audits will be presented by the Medical Records Director at the facility's quarterly quality assurance meetings to ensure ongoing compliance. | |

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| F 157 | Continued From page 4<br>should have been notified on 7/11/16 in the morning. | F 157 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>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.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to code the Minimum Data Set | F 278 | PLAN OF CORRECTION: 483.10 F278<br>The statements made on this plan of | 8/15/16 |

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| F 278 | Continued From page 5<br>(MDS) assessment accurately in the areas of physical restraints for 1 (Resident #62) of 1 sampled resident with a restraint, Activities of Daily Living (ADL) for 1 (Resident #86) of 3 sampled residents reviewed for ADL and active diagnoses for 1 (Resident #75) of 5 sampled residents reviewed for unnecessary medications. Findings included:<br><br>1. Resident #62 was admitted to the facility 10/3/12 and last readmitted on 4/25/14. Cumulative diagnoses included: atrial fibrillation, diabetes, long term use of anticoagulants, Parkinson's disease, anxiety, major depression disorder.<br><br>A review of a side rail assessment dated 6/15/16 stated Resident #62's mental function fluctuated with periods of confusion at night. She was non-ambulatory and no falls were noted in the last 6 months. An assist rail was used by Resident #62 for bed mobility. The side rail assessment stated to continue the use of the side rails.<br><br>A review of Resident #62's medical record revealed Resident #62 had been using the same air mattress since 5/30/2014 and the assist rails that had been on the bed were put on 7/27/2015.<br><br>A Quarterly Minimum Data Set dated 6/22/16 indicated Resident #62 was moderately impaired in cognition. She required extensive assistance of two people for bed mobility. Functional limitation in range of motion was limited on one side upper and one side lower extremity. The assessment further indicated that a physical restraint was not used in bed by the resident.<br><br>On 7/20/16 at 2:29PM, an interview was | F 278 | correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br>For all residents and families affected:<br>1. Resident #62-The Minimum Data Set was modified on 8/10/16.<br>2. Resident #75-Active diagnoses were added to the resident's chart. The Minimum Data Set was modified to reflect documented diagnoses on 8/9/16 by MDS nurse.<br>3.. Resident #86- The Activities of Daily Living section of the Minimum Data Set was modified to reflect documented coding of locomotion on 8/9/16 by the Minimum Data Set nurse.<br>On 7/14/16, the Minimum Data Set nurse was in-serviced by the Director of Nursing that the Minimum Data Set must be coded accurately, which includes review of documentation, use of observation and use of staff interviews, as necessary. In addition, the Minimum Data Set nurse was in-serviced on the importance of documenting observations and interview findings.<br>For all residents that have the potential to be affected:<br>An audit will be completed by nurse consultant, Minimum Data Set nurses, and Medical Records Director by 8/12/16 | |

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| F 278 | Continued From page 6<br>conducted with the Minimum Data Set coordinator who stated Resident #62 would roll over in bed and hold onto the assist rail when personal care was being provided thus providing her with the ability to actively participate in her care. She stated, due to that information, she did not code the assist rail as a restraint.<br><br>On 7/14/16 at 8:18 AM, an interview was conducted with the Director of Nursing who stated the expected the MDS coordinator to code the MDS accurately.<br>2. Resident #75 was admitted to the facility on 9/2/14 with multiple diagnoses including Hypokalemia, Anxiety and Deep Vein Thrombosis (DVT).<br><br>The quarterly MDS assessment of Resident #75 dated 4/25/16 was reviewed. The assessment indicated that Resident #75 had received Potassium Chloride (used to treat Hypokalemia), Buspar (used to treat anxiety), and Eliquis (used to treat DVT) during the last 7 days. Section I (Active Diagnoses) of the MDS assessment did not indicate that Resident #75 had active diagnoses of Hypokalemia, Anxiety or DVT.<br><br>The April 2016 Medications Administration Records (MARs) for Resident #75 were reviewed. The MARs revealed that Resident #75 had received Eliquis, KCL and Buspar during the look back period.<br><br>On 7/14/16 at 8:02 AM, the MDS Nurse was interviewed. The MDS Nurse acknowledged that she missed to code the diagnoses DVT, Anxiety and Hypokalemia under the active diagnoses. | F 278 | to ensure that assist rails, activities of daily living, and diagnoses have been coded accurately on the Minimum Data Set for all residents.<br>Because all residents have the potential to be affected, all employees who complete portions of the Minimum Data Set, including the Minimum Data Set nurses, Food Service Director, Social Services, Activities, Life Enrichment Director, Resident Care Coordinator, and Staff Development Coordinator, were in-serviced by the organization's nurse consultant on accurate assessment and completion of Minimum Data Set, including but not limited to accurate assessment of activities of daily living, active diagnoses and restraints.<br>Education was completed on 8/9/16.<br>Systemic changes:<br>All licensed nurses and certified nursing assistants will be in-serviced by the Staff Development Coordinator, Director of Nursing, or Minimum Data Set nurses on coding of activities of daily living and how to document properly. This will be completed by 8/15/16. For licensed nurses and certified nursing assistants that cannot be reached in person or by phone by this date will be in-serviced prior to their next scheduled shift. Minimum Data Set nurses were in-serviced on 8-9-16 by the organization's nurse consultant on accurate assessment of activities of daily living, active diagnoses and restraints.<br>Monitoring plan to ensure solutions are sustained:<br>Medical Records will complete audits on | |

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| F 278 | Continued From page 7<br>On 7/14/16 at 8:21 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessment accurately.<br><br>3. Resident #86 was admitted to the facility on 4/26/16 with multiple diagnoses including Hip fracture. The MDS assessments were reviewed. The 30 day assessment dated 5/24/16 indicated that Resident # 86 needed extensive assistance (3) with one person assist with locomotion off unit.<br><br>The "certified nursing assistant (CNA) - Activity of Daily Living (ADL) tracking" forms for ADL were reviewed. The form for the look back period of 5/24/16 (30 day assessment) indicated that Resident #86 was coded needed limited assistance (2) twice, extensive assistance (4) once and the rest were activity did not occur (8) under locomotion off unit.<br><br>On 7/13/16 at 3:45 PM, the MDS Nurse was interviewed. The MDS Nurse reviewed the ADL tracking form and the MDS assessment and stated that the coding for the locomotion off unit was not correct, it should have been coded as a 2 instead of a 3.<br><br>On 7/14/16 at 8:21 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessment accurately. | F 278 | five residents three times a week for four weeks (starting week of 8/8/16) to ensure that all diagnoses on the are on the diagnosis list, and then will audit five residents monthly for the remainder of the year.<br>Starting the week of 8/15/16, the Director of Nursing or Staff Development Coordinator will audit five residents a week for four weeks, then five residents a month for the remainder of the year to ensure the activities of daily living, diagnoses, and bed rails and restraints are coded correctly on the Minimum Data Set. Results will be reported at the quarterly Quality Assurance meeting by the Director of Nursing or Staff Development Coordinator to ensure ongoing compliance. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must | F 309 | | 8/15/16 |

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| F 309 | Continued From page 8<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, family interview and record review the facility failed to have a staff member remain with a choking resident while a nurse was summoned for 1 of 1 resident ' s (Resident #85). The findings included:<br>Resident #85 was admitted 6/12/15 and had cumulative diagnoses including vascular dementia, diabetes and muscle spasms.<br>The Quarterly Minimum Data Set (MDS) assessment dated 6/22/16 revealed Resident #85 was cognitively impaired and required extensive assistance with eating. It also indicated Resident #85 had a potential swallowing problem as she would hold food in her mouth/cheeks or have residual food in her month after meals.<br>Review of the Speech Language Pathology Discharge Summary dated 7/1/16 revealed that Resident #85 was discharged to Restorative Nursing with the following ongoing goals and concluding status: " mod (moderate) cues, patient continues to require consistent supervision during meals; she is in the restorative dinning program " and " min (minimum) pocketing (holding food in mouth instead of clearing it when swallowing), no vomiting episodes recently. "<br>Review of the Care Plan last updated 7/4/16 revealed a plan of care for " I need help getting ready for the day d/t (due to) my disease process. | F 309 | PLAN OF CORRECTION: 483.25 F309<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br><br>For all residents and families affected:<br>Resident #85 was evaluated by the nurse practitioner and a chest x-ray obtained on 7/6/16 following the event. Resident had no negative outcomes as a result of the event on 7/6/16.<br>For all residents that have the potential to be affected:<br>Restorative nursing assistants were in-serviced by the Director of Nursing on 7/6/16 on proper procedures for emergency situations, which includes: if there are only two certified nursing assistants (CNA) and an emergency arises, one CNA is required to stay with | |

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| F 309 | Continued From page 9<br>" One of the approaches was to provide assistance with eating.<br>Review of the Restorative order dated 7/4/16 included " provide verbal cues encourage res (resident) to feed herself. "<br>An Acute Condition Nursing Note dated 7/6/16 at 2:20 PM revealed " Shortness of breath Resident choked on carrot while eating lunch. No coughing spells noted prior to incident. Resident witnessed to gasp with head down, staff called to greenroom dining area (restorative dinning), Heimlich maneuver performed, resident was then started responding and coughing afterwards. "<br>The time of the incident was listed as 12:15 PM and a contributing factor was listed as " resident packing food in mouth. "<br>Review of a typed statement prepared by the Director of Nursing and dated 7/6/16 revealed that Nurse #4 and Nurse #7 told the DON that " they heard the restorative aides yelling for help. When they entered the room, they observed (Resident # 85) in her wheelchair with her head down. Nurse #7 reported she lifted (Resident #85) up and (Resident #85) was breathing. " " (Resident #85) was immediately assessed by Nurse #4 and orders were obtained for a chest x-ray.<br>A chest x-ray report dated 7/6/16 had the impression of the x-ray results listed as " stable chest " .<br>On 7/12/16 at 8:54 AM interview with Nursing Assistant #4 (NA #4) revealed that on 7/6/16 she was one of the Restorative Aides assisting residents with lunch in the Restorative Dining Room. She said that they had just passed the lunch trays to the residents and had just started assisting them when the incident occurred. NA #4 indicated and she was sitting between Resident #85 and another resident but was | F 309 | the resident and one is required to go get help. The CNA's were educated that if they are trained in the Heimlich maneuver and they can accurately identify signs and symptoms of choking, then they should perform the Heimlich maneuver. CNA's were also trained on how to identify signs and symptoms of choking. Since all residents have the potential to be affected, all nursing staff will be in-serviced on proper procedures for emergency situations by the Administrator, Minimum Data Set (MDS) nurses, Director of Nursing or Staff Development Coordinator by 8/15/16. All restorative nursing assistants were cardio-pulmonary resuscitation trained, which includes the choking maneuver, by 7/20/16.<br><br>Measures put in place to ensure deficient practice will not occur again:<br>Nurses are present in the main dining room during meals. The nurse in the main dining room during meals is either the charge nurse, the wound nurse, or the floor nurse. Restorative nursing assistants are required to have walkie talkies when in restorative dining in order to call for assistance if needed. New nursing staff will be trained on the choking maneuver during orientation, as well as proper procedures for emergency situations.<br><br>Monitoring plan to ensure solutions are sustained:<br>Starting week of 8/15/16, the restorative nurse (Minimum Data Set nurse) or the | |

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| F 309 | Continued From page 10<br>assisting the other resident to eat but then noticed Resident #85 had her head down and looked like she was sleeping. NA #4 stated she shook the resident a little to wake her up but she did not respond and did not look like herself. NA #4 said she did not observe any coughing, choking sounds from the resident, or skin color changes at that time. She stated that another NA (NA #5) was also in the room and they both went to the door and yelled for help but did not see anyone. NA #4 said she then told NA #5 that she would go find someone and then left the room and went down the hall some to the left. NA #4 added that NA #5 also left the Restorative Dining Room and went to the right towards the break room. According to NA #4, Nurse #4 and Nurse #7 got to the room very quickly as NA #5 had located them in the break room. NA #4 stated that she was aware that at least 1 staff member should have stayed with the resident but said they both panicked and just wanted to get help. She added that it all had happened very quickly and she was on her way back to the Restorative Dining Room when Nurse #7 and Nurse #4 arrived. NA #4 also said that the family member of another resident (Family Member #1) has been in the Restorative Dining Room at the time of the incident.<br>On 7/12/16 at 9:22 AM NA #5 was interviewed. She stated that she was one of two NA ' s in the Restorative Dinning Room for lunch on 7/6/15. NA #5 stated that she was standing by the second of two tables in the room (not the table that Resident #85 sat at) at that time. NA #5 revealed that Resident #85 had been sitting in her wheelchair at the first table, in the first seating space, by the entrance to the room. NA #5 said she did not observe any signs of choking but could just tell something was wrong with Resident | F 309 | Facility Supervisor will observe a restorative dining meal twice weekly for one month, then once a week for two months, then once a month for the remainder of the year. During the first month of observations, at least two observations will occur on the weekend, during the next two months, at least four observations will occur on the weekend. The MDS nurse or the Facility Supervisor will observe during meals to ensure restorative CNAs have walkie talkies, verify that staff remain in the room at all times during meals, and confirm understanding of proper procedures during emergency situations. Results of observation will be recorded on an established form and then reported at the quarterly Quality Assurance meeting. The restorative nursing assistants will sign this established form during each meal observation completed by the Minimum Data Set nurse or the Facility Supervisor. | |

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#85 and that her head was hanging down. She said she was aware that Nurse #7 was usually in the Main Dining Room at that time of day and that she just wanted to go and find her immediately so she left the room and did not know if NA #4 was still in the Restorative Dining Room when she left or not due to adrenalin. NA #5 also said that she and did not recall any discussion with NA #4 about leaving the room. NA #5 said she hollered for Nurse #7 in the dining room but did not see her so tried the break room which was also close by and found Nurse #4 and Nurse #7. NA #5 also said that the family member of another resident (Family Member #1) has been in the Restorative Dining Room at the time of the incident.

On 7/12/16 at 9:40 AM Family Member #1 (family member of another resident not Resident #85) was interviewed by telephone. She stated that she had been in the Restorative Dining Room for lunch on 7/6/16 assisting her mother who was sitting directly across from Resident #85. Family Member #1 said Resident #85 started choking. She indicated that she could tell the resident was choking because Resident #85 was acting like she could not get any air and had spittle coming out of her mouth and because the NA beside Resident #85 (NA #4) said ' I think she ' s choking ' . Both of the NA ' s in the room got excited, started yelling and ran out the door to get help. Family Member #1 said the resident ' s eye ' s then rolled and she slumped over. Family Member #1 indicated she had some health care background and when the resident slumped forward she got up walked around the small table and gave Resident #85 two good Heimlich thrusts. She said she saw something fly out of the resident ' s mouth but did not know what it was. Resident #85 then sucked in a big breath and started coughing and then Nurse #7 arrived.

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On 7/12/16 at 10:00 AM Nurse #7 was interviewed by telephone. She said she had been in the hall at the time of the incident and then recalled she had been in the break room when she heard the Restorative Nursing Assistants calling for help. She stated that when she got to the Restorative Dining Room a family member of another resident was standing beside Resident #85. Nurse #7 said that she had the family member move away so she could assess the resident and very quickly saw, by watching her chest that Resident #85 was not breathing. She added that Resident #85 was not responding and had snot coming out of her nose. Nurse #7 said she did two Heimlich thrusts and did not see anything come out of the resident ' s mouth but Resident #85 lifted her head after the second one and started coughing a lot.

On 7/12/16 at 10:38 AM the Nurse Practitioner NP was interviewed. She stated that she assessed Resident #85 in the resident ' s room approximately 10 minutes after the incident occurred and that to be cautious she ordered a chest x-ray. She added that Resident #85 had not choked before and was just in Restorative Dinning as a precaution. She added that she did not think that Resident #85 had been put at additional risk when both NA #4 and NA #5 left the Restorative Dining Room in an effort to get help as soon as possible. She felt that as Nursing Assistants their first reaction to an emergency was to get help from a Nurse and that was what they did.

On 7/14/16 at 11:32 AM interview with the MDS Coordinator/Restorative Coordinator revealed that it was preferable for at least one Restorative Aide (NA #4 or NA #5) to stay with the residents in the Restorative Dining Room while the other went for help. She said she did not think the NA '

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| F 309 | Continued From page 13<br>s knew that Resident #85 was choking.<br><br>On 7/14/16 at 2:01 PM Nurse #4 was interviewed. He stated that at the time of the incident he was in the break room with Nurse #7 eating lunch. He said they heard someone call for help and then heard Nurse #7 ' s name and when they came out NA #5 told them there was an emergency situation in Restorative Dinning. He stated that Nurse #7 entered the Restorative Dining Room and all he saw was Nurse #7 behind Resident #85 with her arms around her and her back towards Nurse #4 (Resident #85 sat near the doorway with her back towards the doorway). He said he did not know if she gave any thrusts because he did not see it.<br><br>On 7/14/16 at 2:30 PM the Director of Nursing was interviewed (DON). The DON stated she had not been aware that the Nursing Assistants had left the room to get help. She said she was told they had been yelling for help from the door. She indicated that her expectation was that one staff member stay with the resident and that the other one could go and get help. She added that Nursing Assistant staff in North Carolina were not required to be trained in the Heimlich maneuver or Cardio Pulmonary Resuscitation. | F 309 | | |
| F 323 SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | | 8/9/16 |

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| F 323 | Continued From page 14<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, facility policy review, physician, nurse practitioner and staff interviews, the facility failed to safeguard a resident from entrapment between the side rail and the air mattress. On 7/10/16 at 9:40PM, Resident #62 fell between the air mattress and the bed rail causing her head to become wedged between the rail and the air mattress.<br><br>Immediate jeopardy began on 7/10/16 and was removed on 7/14/16 at 3:50PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems have been put into place and are effective and all staff have been in-serviced.<br><br>A manufacturer's user guide for the (name) mattress was reviewed. The manufacturer ' s guide stated "the air mattress in the mattress replacement is continually monitored and a visual and audible alarm activates in the event mattress pressure becomes too low." There were no manufacturer's instructions noted for the use of the air mattress with an assist rail.<br><br>Resident #62 was admitted to the facility 10/3/12 and last readmitted on 4/25/14. Cumulative diagnoses included: atrial fibrillation, diabetes, long term use of anticoagulants, Parkinson's disease, anxiety, major depression disorder. | F 323 | PLAN OF CORRECTION: 483.25 F323<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br><br>For all residents and families affected: Resident #62 was immediately assessed for injury at time of incident on 7/10/16 at 9:40 pm. No markings or bruising were noted. Physician was notified and an order received for an x-ray, which was obtained at 12:26 am on 7/11/16. Physician notified of results of x-ray and ordered for nurse to leave a note for the morning to make an appointment for resident to see the orthopedic surgeon. The nurse practitioner assessed resident that same day and ordered further assessment at ED; resident sent out at 2:43 pm on 7/11/16. A computerized tomography (CT) scan was obtained which noted no injury from incident. Assist rails were removed from bed on 7/11/16. Bed repositioned and mats placed on each side of bed. Resident re-assessed for need for assist rails. Care plan | |

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| F 323 | Continued From page 15<br>On 7/12/16, a review of Resident #62's medical record was conducted. Information provided by the facility revealed Resident #62 had been using the same air mattress since 5/30/2014 and the assist rails that had been on the bed were put on 7/27/2015.<br><br>A review of a facility assessment for the use of side rails dated 6/15/16 stated Resident #62's mental function fluctuated with periods of confusion at night. She was non-ambulatory and no falls were noted in the last 6 months. An assist rail was used by Resident #62 for bed mobility. The use of the assist rail was not coded on the MDS as a restraint.<br><br>A Quarterly Minimum Data Set dated 6/22/16 indicated Resident #62 was moderately impaired in cognition. She required extensive assistance of two people for bed mobility. Functional limitation in range of motion was limited on one side upper and one side lower extremity.<br><br>Medical record review conducted on 7/12/16 revealed Resident #62 also had times when she moved about in bed independently without staff assistance.<br><br>A Care Plan dated 11/17/15 and last revised on 7/12/16 stated Resident #62 was at a risk for falls due to her history of falls. Approaches included, in part, to instruct Resident #62 on safety. Staff would observe, record and report all unsafe conditions and situations. Resident #62 had a low bed and a floor mat beside the bed. Encourage her to ask for assistance. The use of floor mats on both sides of the bed when Resident #62 was in bed was added to the approaches on 7/12/16. | F 323 | updated to reflect no further need for assist rails on 7/11/16. Air mattress assessed for proper function and inflation on 7/11/16. All zones were measured to ensure that no gaps exceed limits for hospital beds established by the FDA by administrator on 7/11/16. On 7/14/16 the air mattress manufacturer came to the facility to look at the mattress to verify it was working properly.<br><br>For all residents with the potential to be affected:<br>To identify potential safety risks for all other residents; beds, mattresses, and side rails in facility were measured to ensure that no gaps exceed limits for hospital beds established by FDA using a bed safety checklist. This process began on 7/12/16 and was completed on 7/13/16 by the Maintenance Director, Director of Clinical Reimbursement, Resident Care Coordinator, Minimum Data Set (MDS) Nurse, Environmental Services Director, Housekeeper, Medical Records Director, and Billing Office Manager. All residents with air mattresses were assessed for need for assist rails on 7/12/16, and as new residents receive orders for an air mattress they are assessed immediately. The air mattresses were assessed for proper fit by applying pressure to the mattress to assess if there was a gap between the side rails, if there were side rails, and the mattress.<br><br>System Changes and measures to ensure deficient practice will not reoccur:<br>All beds and mattresses will be checked | |

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| F 323 | Continued From page 16<br><br>A review of falls for Resident #62 over the past two years revealed the following falls recorded: 3/19/14 (nursing note stated fell from wheelchair), 9/7/15 (observed on floor and did not call for assistance when trying to get up) and 7/11/16 (wedged in between mattress and side rail).<br><br>A nursing note dated 7/11/16 at 2:28AM stated "observed on mat next to bed. Resident observed laying on stomach with neck stuck in between bed rail and bed, body straight out half on bed, half off bed, legs straight out touching the floor mat, arms at side. Bed was in low position. Floor mat was down. Upon resident being put back to bed, full assessment and skin assessment was completed. Signs and symptoms of pain were presented when the anterior left side of neck was palpated. No swelling, redness or bruising was noted." The Physician on call was called and new orders were received. The time of incident was documented as follows: 7/10/16 at 9:40PM. The equipment involved was documented as bed rails.<br><br>An x-ray of the cervical spine dated 7/10/16 indicated the following: Impression linear lucency within the anterior aspect of the C4 vertebral body, consistent with a fracture.<br><br>A nursing note dated 7/11/16 at 2:43 AM stated the on-call physician was notified of the results. The on-call physician stated for the in house physician to see resident in the morning and for resident to see orthopedic physician.<br><br>An observation of Resident #62 was conducted on 7/11/16 at 12:40PM. Resident #62 was lying in her bed. She had an alternating air mattress in | F 323 | by the maintenance staff using the Bed Safety Checklist quarterly. Any necessary actions needed will be taken at the time of the audit. The maintenance department will check each bed to ensure the bed rails continue to fit properly (if there are bed rails), once a week for every resident that has an air mattress, starting the week of 8/15/16. Any resident with an air mattress will have their air mattress checked every shift by a nurse or medication aide, and recorded on the Medication Administration Record, to ensure that it is inflated properly. The nurses are required to check the setting of the air mattress for proper inflation by looking at the air mattress settings and ensuring they are set according to manufacturer's guidelines. The manufacturer guidelines for the air mattresses are provided in a notebook in the nurse's station for the nurses to reference. Staff education began on 7/11/16 and was completed 7/14/16 by the Staff Development Coordinator (SDC), Director of Nursing (DON), and the MDS Nurse. Staff that were on vacation or unable to be reached were trained prior to their next working shift. Education included the following:<br>Written protocol, created on 7/12/16, for immediately reporting serious incidents, including any incident involving a bed rail, elopement, abuse, neglect, serious injury, resident altercation, or anything deemed unusual by a licensed nurse, to Administrator and DON. All staff that are non-licensed were in-serviced that any incidents should immediately be reported | |

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| F 323 | Continued From page 17<br>place. There were 2 assist rails on either side of the bed near the head of the bed. The air mattress was soft to touch. There was a small gap between the air mattress and the side rail. Area was not measured at that time.<br><br>On 7/11/16 at 1:45PM, Resident #62 was seen by the Nurse Practitioner and orders were given to send Resident #62 to the hospital emergency room for evaluation and for a computerized tomography (CT) scan of the cervical spine.<br><br>A CT scan of the cervical spine without contrast dated 7/11/16 stated the following: Findings: Normal alignment. No evidence of fracture. There is multilevel cervical spondylosis (neck arthritis) with posterior disc osteophyte (bone spur) complexes and bilateral facet hypertrophy (degeneration and enlargement of joints). Impression: cervical spondylosis without evidence of cervical fracture or malalignment.<br><br>A review of Resident #62's medical record revealed neurological checks were done from the time of the incident through 7/11/16 at 11:30PM and all were normal.<br><br>On 7/11/16 at 4:55PM, an interview was conducted with the Administrator who stated she was not aware of the accident involving Resident #62 until the morning meeting on Monday 7/11/16. She stated Resident #62 had rolled in her bed, had a hand rail on the side of the bed and got positioned between the mattress on the bed and the handrail. Resident #62 had some pain in her neck; the facility obtained an order for x-ray and the x-ray results stated a possible fracture. The on call physician was called and he stated to have the nurse practitioner see Resident | F 323 | to the charge nurse.<br>Licensed and non-licensed staff were re-educated on Bed Safety and Side Rails policy and Accidents and Incidents-Residents policy. (These are existing corporate policies)<br>Licensed Nurses and Medication Aides were in-serviced that air mattress documentation will now be on the Medication Administration Record and they will be required to check them every shift, every day.<br>All facility staff were in-serviced on the potential risk of injury if there is a gap between the mattress and the assist rails and the importance of reporting any gap of concern to the charge nurse immediately.<br>All nursing staff were in-serviced on proper use and inflation of air mattresses per manufacturer guidelines (manufacturer representative also trained nursing staff who were present on 7/13/16 on the air mattress functioning).<br>Monitoring plan to ensure solutions are sustained:<br><br>The Maintenance Director will report findings of completed Bed Safety Checklist at the quarterly Quality Assurance meeting, as well as results of weekly checks for beds with air mattresses. The Resident Care Coordinator or Medical Records Director will audit the MAR for residents who have an air mattress twice a week for three months, once a week for three months, once a month for three months to ensure that the air mattress checks are being | |

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| F 323 | Continued From page 18<br>#62 today (7/11/16). She said her expectation was the following: if a resident has a fall with major injury, call the physician and family; if the resident was sent out to the hospital, she expected them to call the on call nurse or Director of Nursing. If it was an injury of unknown origin, to call the Administrator also. She stated the charge nurse removed the hand rails on that resident's bed on 7/11/16 sometime after lunch on 7/11/16.<br><br>On 7/11/16 at 5:09PM, an interview was held with Nurse #3 who was the nurse who completed the accident investigations for falls. She stated she only knew what was in the medical record that Resident #62 fell yesterday at 9:40PM. In looking at the nursing notes, her head was pinned between the rail and the mattress. She stated they had taken the side rails off Resident #62 ' s bed sometime after lunch on 7/11/16 due to the nursing documentation about the way Resident #62 had her head in the rails. She stated Resident 62 was trying to turn over in the bed and rolled off the bed. She could turn over by herself. Nurse #3 stated the same rails were on all the beds. Nurse #3 said Resident #62 had a regular pressure reducing standard mattress and she did not know if it was an air mattress. She stated all falls are investigated within the first day. The daily condition sheets were brought into morning meeting and reviewed go over them, anything out of the ordinary like falls starts the investigation that day. Nurse #3 stated she had not come to the morning meeting and had not had a chance to speak to anyone yet about the accident. She stated Resident #62 could not walk and, if her legs were going off the bed, her body weight would carry her lower body but her head could still be in the bed rails even if the bed | F 323 | completed. | |

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was low to the floor.

On 7/11/16 at 5:40PM, an interview was conducted with the Director of Nursing. She stated she got in the facility around 11:30AM on 7/11/16. She could not remember exactly when she was made aware of the accident involving Resident #62. She stated Nurse #4 was going to let the Nurse Practitioner see Resident #62 because the on call physician stated for the Nurse Practitioner to see her on 7/11/16. The Director of Nursing stated she spoke to Nurse #1 who was present at the time of the accident and Nurse #1 told her she was called to the room by other nursing staff due to the positioning of Resident #62 who was positioned between the bed and the rails and her head was "in the railing" so they immediately moved Resident #62 because they had to. She stated Nurse #1 told her she called the on-call doctor and explained what happened and the on-call doctor stated Resident #62 should be all right and ordered a cervical spine x-ray. The results of the x-ray were obtained around midnight. Nurse #1 called the on call physician and he said to just let the Nurse Practitioner see her in the morning. The Director of Nursing stated she expected nursing staff to call her if a resident was sent out to the hospital. She stated they should have called her if it was a side rail injury. If she had received a call, she would have told them to send Resident #62 to the hospital anyway. She said she would have removed the side rails at the time of the accident.

On 7/11/16 at 6:05PM, an interview was conducted with Nurse #2 who stated she and another nursing assistant (NA#1) were coming back up the hall on B hall and were spot-checking the rooms. As they came up the hall, they saw

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that the bedspread and sheet were hanging off the foot of Resident #62's bed. Resident #62 was able to get her legs off the bed so they went in to check her because the curtain was pulled and they could not see her from the hallway. Resident #62 had her head wedged in between the side rail and the bed itself. She had one hand on the side rail. Her knees were actually on the floor. She talked to nursing staff and said she slid out of bed. She still had her oxygen cannula on and was facing the headboard. Her head was wedged at the eye area. Nurse #2 stated Resident #62 could not physically move herself.

On 7/11/16 at 6:15PM, an interview was conducted with NA#1, the nursing assistant who was assigned to Resident #62 on 7/10/16 when the accident occurred. She stated she last saw Resident #62 on 7/10/16 between 8:15-8:30PM. NA#1 said she was going to see her nurse to tell her about one of her residents when she looked in Resident #62's room and saw the bed covers on the floor. She said she was by herself when she went in the room and immediately called for Nurse #2 to come in the room. NA#1 said she could not see the resident at all from the outside of the room. Her backside was exposed her head was facing down with her head between the rail and the mattress. Resident #62 was calling for help in a low toned voice. NA#1 stated Resident #62 did not complain about any pain on any part of her body.

On 7/11/16 at 6:23PM, an interview was conducted with Nurse #1 who was in charge of Resident #62 on 7/10/16. She said she was working on the hall and had just finished up medication pass. Resident #62 had received a bedtime snack between 8:30-9:00PM. Nurse #1

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stated one of the nursing assistants went into Resident #62's room around 9:40-9:45PM. Nurse #1 was called to the room. Resident #62's bed was in the lowest position and her floor mat was in place on the floor. Resident #62 had her head in between the rail and the air mattress with the left side of her face was on the rail and the right side of her face was pressed against the side of the air mattress. Her face wasn't on the mattress. There was an open space under her chin. Her whole head and neck was in between and she was looking down-neck was down. Her feet were stretched out on the floor mat and her knees were almost on the floor mat. Resident #62 had her eyes open and she did not speak. She was breathing normally but Nurse #1 felt it was an unsafe position for her to be in and she, along with two other staff members (Nurse #2 and NA#1), log rolled her back onto the bed. Resident #62 was not in pain or hurting when she was moved back onto the bed. Nurse #1 said she asked Resident #62 if anything hurt and initially Resident #62 did not say anything. Nurse #1 asked her about her neck, head, ears and she said it hurt when Nurse #1 pressed on the left side of her neck and if it wasn't touched, it did not hurt. Nurse #1 stated neurological checks were initiated, vital signs were done and Resident #62 squeezed Nurse #1's hands and moved her feet on command. Resident #62 had no redness, bruising or swelling only pain when Nurse #1 touched her neck. Nurse #1 called the on-call doctor and he ordered a spinal x-ray and he said it could be done in the morning. The mobile x-ray personnel were in the building so the x-ray was obtained that night and the results from the x-ray came in around 1:00AM. Nurse #1 called the on-call physician immediately and he said to let the physician see her in the morning and get an

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appointment for orthopedic consult. Nurse #1 said she wasn't concerned about the rail as she repositioned Resident #62 better in the bed and not as close to the floor mat area. She stated she felt it was safe at the time and the resident was in no danger. Nurse #1 stated she did not call the on-call person for the facility because the on-call doctor stated Resident #62 would be all right.

On 7/11/16 at 7:07PM, an interview was conducted with NA#2 who was a nursing assistant who also worked 7/10/16 on the evening shift. He stated he was on B hall charting and Nurse #1 and #2 were at their medication carts. He stated he was called to the room and Resident #62 was halfway on the floor and her head was wedged between the bed rail and the mattress and her knees were on the mat. The bed was in the lowest position. She was alert. He stated that he, NA#1 and Nurse #1 scooted Resident #62 back on the bed.

On 7/11/16 at 7:20PM, an interview was conducted with the Administrator. The Administrator stated they did not have a process in place for checking the gap between the side rails and the air mattress. She stated the housekeeper checked the air mattress for correct size and function of the air mattress when she put it on the bed. No one checked for the gap between the side rails and the air mattress.

An observation of Resident #62 was conducted 7/12/16 at 7:45AM. Resident #62 was lying in bed with the head of the bed slightly elevated. She was lying on an alternating air mattress. The setting of the mattress was checked and revealed 2 green lights were lit which indicated "soft" .

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The bed was in the lowest position and the mat was on the floor. There were no side rails on the bed at the time of the observation.

On 7/12/16 at 8:36AM, an interview was conducted with the Minimum Data Set (MDS) coordinator who stated she removed the bed rails on Resident #62's bed around 1:00PM on 7/11/16. She stated Resident #62 had one of the newer beds and the bed rails were not loose on either side of the bed. She removed the rails by pushing a button that was on the bottom of the rail. Regarding the air mattress and monitoring of the pressure in the air mattress, she stated the air mattress had an alarm that sounded whenever the pressure was too low or there was a problem with the mattress.

On 7/12/16 at 9:30AM, an observation of the bed rails and air mattress of Resident #62 was conducted with the Maintenance director. At that time, the bed rails are affixed to the bed by putting the base of the rail into a round opening at the base of the bed frame. Both of the rails were able to be moved slightly outward. Per the Maintenance supervisor, there was no way to tighten the rails more to decrease the movement of the rails. The Maintenance director measured the open gap between the bed rail and the mattress. The right side rail had a gap between the rail and the air mattress of 1 ½ inches when measured without any pressure to the rail. With pressure to the rail to make the rail go outward until the point of resistance, the gap measured 2 ½ inches. With the rail at its most outward position and pressure to the side of the air mattress, the gap measured 4 ½ inches between the rail and the aide of the air mattress. The left side rail had a gap between the rail and the air

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mattress of ¾ inches when measured without any pressure to the rail. With pressure to the rail to make the rail go outward until the point of resistance, the gap measured 1 1/8 inches. The bed rails were then removed from the bed of Resident #62.

On 7/12/16 at 9:30AM, the gap between the side rails and a regular mattress was measured with the left side measuring 1 ¼ inches and the right side measured 1/3/4 inches with the rails moved to the point of resistance.

On 7/12/16 at 9:30AM, Resident #62 was observed moving her lower legs and she stated "I've got to get my legs out." Resident #62 was observed to bend her legs and moved her legs to the side of the bed and she was trying to get her legs off the bed. Nursing staff arrived and assisted her with repositioning.

On 7/12/16 at 10:38AM, an interview was conducted with the Nurse Practitioner. Resident #62's physician was also present during the interview. The Nurse Practitioner stated she examined resident #62. She stated Resident #62 had limited communication and she had some tenderness when the Nurse Practitioner palpated the back of her neck. Resident #62 had a history of osteoarthritis in her spine. Orthopedics could not see her for 2 weeks. The Nurse Practitioner stated she was not comfortable with waiting 2 weeks and ordered her to go the hospital to get a computerized tomography (CT) scan done as a precautionary measure and that was the fastest way to get a CT done. She said she looked at the mobile x-ray results and there was a question as to an actual fracture or not.

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On 7/12/16 at 10:56AM, an interview was conducted with Resident #62's physician who stated, based on his knowledge of the resident, her family, her medical frailty, if he had received the call regarding the mobile x-ray results, he would have sent her to the hospital at that time as a precautionary measure.

On 7/13/16 at 11:40AM, an interview was conducted with the sales representative for the air mattress that was used on Resident #62's bed. He stated the air mattress on the bed was of a standard size. He stated, to his knowledge, there were no alerts or recommendations on the use of the air mattress with any type of side rail.

On 7/14/16 at 11:19AM, an interview was conducted with the on-call physician. He stated the nursing staff did appropriate actions and followed his orders. He stated Resident #62 needed additional x-rays with MRI (Magnetic Resonance Imaging) and/or a CT scan at an x-ray suite at the hospital. The physician stated the resident would not have been "served" by being sent out to the emergency room. He stated the resident needed further care but it was not an emergency situation. He said if there was a fracture, Resident #62 was safer at the nursing home than on a skinny gurney at the emergency room. He chose to keep her at the nursing home and be seen by the provider at the nursing home. He said it was not necessary to use a vertebral collar and the collar could cause more harm than good. A soft c-collar would not stabilize the neck and was only a "neck warmer" .

On 7/14/16 at 11:23AM, an interview was conducted with the Nurse Practitioner. She stated she came to the facility around 12:15 or

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12:30PM. She stated it was about one hour after that (1:30PM) when she was informed about Resident #62's incident. She stated she was told that Resident #62 had an incident on 7/10/16 and her positioning, that the on-call physician was called, given the x-ray results to review. She said she reviewed the x-ray results and examined the resident around 1:45PM and ordered her to go to the hospital for a CT scan. When she did an assessment, she asked resident #62 if she had any pain and she didn ' t answer her. The Nurse Practitioner stated she did not feel any abnormalities. She said she told the nursing staff to put a neck roll around her neck, call EMS (Emergency Medical Services) to send her to the hospital and get a CT scan done. The Nurse Practitioner stated if she had been notified by the facility the first thing on the morning of 7/11/16 and the x-ray results had been read to her, she would have ordered a CT scan. If that could not be obtained within an hour, she would have ordered for the facility to send Resident #62 to the emergency room via ambulance.

On 7/12/16 at 6:22PM, the Administrator and Director of Nursing were informed of the immediate jeopardy. The facility provided a credible allegation of compliance on 7/14/16 at 2:19PM. The allegation of compliance indicated:

Credible Allegation of Compliance:
1. Resident #62 was immediately assessed for injury at time of incident on 7/10/16 at 9:40 pm. No markings, indentations or bruising were noted upon assessment by a licensed nurse. The licensed nurse did note pain during palpitation of Resident #62's neck. Resident #62 was noted to not be in any distress, neurological checks were completed with no abnormalities, and Resident

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#62 was able to have a conversation with staff regarding the situation. Physician was notified on 7/10/16 at around 10:30-11:00 pm and an order was received for an x-ray, which was obtained at 12:26 am on 7/11/16. Mobile X-Ray completed a spine cervical x-ray. The findings of the x-ray were "Linear lucency within the anterior aspect of the C4 vertebral body, consistent with a fracture. Correlate with studies such as CT." Physician notified of results on 7/11/16 at approximately 1:00 am. Nurse Practitioner assessed resident on 7/11/16 at 2:00 pm and ordered further assessment at Emergency Room (ER); Resident #62 sent out at 2:43 pm on 7/11/16. Computerized Tomography (CT) scan obtained at hospital with no injury from incident noted. Resident #62 returned from the emergency room around 7:00 pm.

2. Side rails were removed from Resident #62's bed on 7/11/16 at 1:07 pm. Bed repositioned to allow placement of bed mats on each side of bed on 7/11/16 around 6:30 pm by the Second Shift Supervisor . Resident re-assessed for need for assist rails by the Director of Nursing (DON) on 7/11/16 at approximately 11:30 am. Care plan updated to reflect no further need for side rails on Monday, 7/11/16 at 4:19 pm, by Minimum Data Set (MDS) Nurse.

3. To identify potential safety risks for all other residents, the beds, mattresses, and side rails in the facility were measured to ensure that there was not any "give" and that any compression of the mattress would not allow enough space for a resident to become entrapped. This process began on 7-12-16 at 12:00 pm and will be completed on 7-13-16 by midnight by the Maintenance Director, Maintenance Assistant, Director of Clinical Reimbursement, Care Coordinator, MDS Nurse, Environmental Services

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Director, Housekeeper, Medical Records Director, and Billing Office Manager. These checks will be completed using a bed safety checklist. In addition, on 7-12-16, the Administrator and the Director of Nursing checked every bed in the facility and assessed any gaps in beds that could potentially be dangerous for residents.

4. Residents who have air mattresses were assessed for need for assist rails on 7/12/16 by the Director of Nursing, MDS Coordinator, and Staff Development Coordinator; the rails of two residents, in addition to resident #62, were removed when it was determined that the rails were not needed. The Care Plans for these residents were updated by the MDS Coordinator.

5. Effective 7/13/16, every resident with an air mattress will have a monitoring signoff regarding their air mattress on the Treatment Administration Record (TAR) so that it will be checked daily, every shift, to ensure that it is inflated properly, by the Nurse or Medication Aide.

6. Staff education began on 7/11/16 and will be completed by 7/14/16 by 12:00 pm via in-person or on the phone by Staff Development Coordinator, Director of Nursing, and the MDS Nurse. Staff that are on vacation or unable to be reached will be trained prior to their next working shift. The education will be conducted by the Director of Nursing, Staff Development Coordinator, MDS Nurse, Administrator, and the Clinical Reimbursement Nurse and will include the following:

a. Written protocol, created on 7/12/16, for immediately reporting serious incidents, including any incident involving a bed rail, elopement, abuse, neglect, serious injury, resident altercation, or anything deemed unusual by a licensed nurse, to Administrator and DON. All

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staff that are non-licensed will be in-serviced that any incidents should immediately be reported to the charge nurse.
b. Licensed and non-licensed staff will be educated on Bed Safety and Side Rails policy; Accidents and Incidents-Residents policy. (These are existing corporate policies)
c. Licensed Nurses and Medication Aides will be in-serviced that air mattress documentation will now be on the Treatment Administration Record and they will be required to check them every shift, every day.
d. All facility staff will be in-serviced on the potential risk of injury if there is a gap between the mattress and the assist rails and the importance of reporting any gap of concern to the charge nurse immediately.
e. All nursing staff will be in-serviced on proper use and inflation of air mattresses per manufacturer guidelines (manufacturer representative also trained nursing staff on 7-13-16 on the air mattress).
f. Licensed Nurses will be in-serviced about assessing for need of side rails immediately after an incident occurs involving a side rail. The Charge Nurse or RN on duty will complete the assessment.

The credible allegation was verified 7/14/16 at 3:50PM as evidenced by staff interviews on the policy and procedures for immediately reporting serious accidents to include any accident involving a bed rail, the Bed Rail and Side Rails policy to include notification of accidents with side rails, Air mattress documentation and when/ where that would be documented, proper use and inflation of the air mattress, immediate notification to the charge nurse if an air mattress is alarming , reporting any gap between the side rail and

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| F 323 | Continued From page 30<br>mattress that is of concern to the nursing staff and assessment for the need for side rails. A total of 13 nursing staff had not received the in-service bit Administrative staff stated the remainder of staff would receive the in-service prior to working on the floor.<br><br>All residents with air mattresses and side rails were observed with the side rails removed for 3 residents and no gaps of concern noted on the remaining 2 residents. All residents with air mattresses and side rails had care plans regarding their use and documentation was noted on the Treatment Administration Record. The bed safety check list was reviewed and audits done and completed for 80 residents on 7/13/16.<br>In-service records were reviewed with the following dates noted:<br>Side rails and bed safety, resident accident/ incidents reporting--7/13<br>When to contact the administrator and DON (nursing)--7/11-7/14/16<br>Contacting the charge nurse (Nursing assistants)--7/13/16<br>Air mattress documentation (licensed and med aide) 7/13--7/14/16<br>How to check the air mattress for all nursing staff--7/14/16 | F 323 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | 8/19/16 |

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| F 371 | Continued From page 31<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to consistently monitor and maintain a refrigerator temperature of 41 degrees Fahrenheit (F) or below in one of two nourishment refrigerators (A, B, and C hall nourishment refrigerator). The findings included:<br><br>The facility's food storage policy, dated 7/13/10, was reviewed. The policy read, in part, "[Potentially Hazardous Foods (PHF)/Time Temperature Control for Safety (TCS)] foods must be maintained at or below 41 degrees [Fahrenheit (F)] unless otherwise specified by law. Monitor and record temperatures of refrigeration at least daily and at routine intervals during all hours of operation. Temperatures should be taken using internal thermometers. Temperatures greater than 41 degrees F should be reported to the maintenance department immediately."<br><br>An observation of the nourishment refrigerator utilized for the A, B, and C halls was conducted with the Dietary Manager (DM) on 7/13/16 at 9:45 AM. The internal thermometer indicated the temperature was 52 degrees F. Items observed in the refrigerator included yogurt, fruit juices, and med pass (nutritional supplement). The DM stated that staff may have been in and out of the refrigerator that morning causing the temperature to be greater than 41 degrees F.<br><br>A second observation of the nourishment | F 371 | PLAN OF CORRECTION: 483.35-F371<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br>For all residents and families affected:<br>On 7/14/16, a new refrigerator was purchased to replace the malfunctioning refrigerator in the nourishment room.<br>For all residents that have the potential to be affected:<br>All dietary employees will be in-serviced on the facility's food storage policy and the procedures for checking temperatures by the Food Service Director by 8/12/16.<br>All new dietary employees will be in-serviced during orientation on the facility's food storage policy by Food Service Director or the Assistant Food Service Director. The Food Service Director was in-serviced by the Administrator on 7/14/16 regarding the facility's food storage policy, including the requirement to report temperatures outside of acceptable range and/or | |

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refrigerator utilized for the A, B, and C halls was conducted with the DM on 7/13/16 at 11:55 AM. The internal thermometer indicated the temperature was 50 degrees F. Items observed in the refrigerator included yogurt, fruit juices, and med pass. The DM stated the door to the refrigerator had not appeared to be fully closed. She indicated she thought that could have been why the temperature was greater than 41 degrees. She stated she was going to get another thermometer to place inside of the refrigerator to see if the thermometer was the issue.

A third observation of the nourishment refrigerator utilized for the A, B, and C halls was conducted with Nursing Assistant #3 on 7/13/16 at 3:40 PM. There were two internal thermometers in the refrigerator. Thermometer #1 indicated 50 degrees F and thermometer #2 indicated 51 degrees F. Items observed in the refrigerator included yogurt, fruit juices, and med pass.

The nourishment refrigerator utilized for the A, B, and C halls had the refrigerator temperature log located on the right hand side of the refrigerator. The log indicated the refrigerator temperatures were to be recorded daily on the 11-7 shift. The temperature log from January 1, 2016 through July 13, 2016 was reviewed and revealed 49 distinct calendar days that the temperature was not recorded.

A focused reviewed of the temperature log from June 21, 2016 through July 13, 2016 indicated that on 4 distinct calendar days the temperature was not recorded and on 14 out of 18 distinct calendar days the recorded temperature was greater than 41 degrees F. The following details

concerns with the refrigerator to the maintenance department immediately.
Measures put in place to ensure deficient practice will not recur:
The Food Service Director was in-serviced on 7/14/16 that it is now the responsibility of the kitchen to check the temperatures of the refrigerators and freezers in the nourishment rooms daily and to document temperatures on daily log. The temperatures will be checked by the Food Service Director daily Monday-Friday, and in her absence the Assistant Food Service Director will check the temperatures. On the weekends, the dietary aide will be responsible for checking the temperatures daily and reporting any low temperatures immediately to the maintenance person that is on-call or to the Administrator. On Monday, the Food Service Director, or assistant Food Service Director will check the log from the weekend to ensure that the temperatures were recorded and that there are no concerns with recorded temperatures.
Effective 8/19/16, all maintenance work orders will be completed on a duplicate carbon copy form by the person who recognized a problem or concern, and the top copy will be given to the maintenance department and the bottom copy will be kept in the nurses' stations in a separate container. Once the work is completed, the maintenance employee will return the top copy of the work order to the ward clerk, with initials and dated completed. The ward clerk will find the bottom copy and staple the top copy together. The

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| F 371 | Continued From page 33<br>were revealed:<br>- 1 recorded temperature of 70 degrees F (7/4)<br>- 5 recorded temperatures of 50 degrees F (6/21, 6/27, 6/28, 7/9, 7/10)<br>- 3 recorded temperatures of 48 degrees F (6/29, 6/30, 7/2)<br>- 2 recorded temperatures of 46 degrees F (6/22, 7/7)<br>- 3 recorded temperatures of 44 degrees F (6/23, 6/26, 7/1)<br><br>An interview was conducted with the DM on 7/13/16 at 3:45 PM. She stated her expectation was for the temperature of the nourishment refrigerators to be recorded daily on the log and for the internal temperature to be 40 degrees or below. She indicated nursing staff were supposed to complete the temperature log daily. She stated she had not known if anyone reviewed the temperature log of the nourishment refrigerators. She reported that she had not monitored the temperatures of the nourishment refrigerators and she had not reviewed the temperature logs. She revealed when the observations were conducted this morning of the nourishment refrigerator utilized for the A, B, and C halls she had not known why the temperatures were so high.<br><br>An interview was conducted with the Maintenance Director on 7/13/16 at 5:10 PM. He revealed he had just located a repair order completed on 7/6/16 by nursing staff that indicated the nourishment refrigerator utilized for the A, B, and C halls was not sealing closed. He indicated he had not seen the repair order prior to this afternoon (7/13/16). He stated that was no excuse and that he was going to look at the refrigerator immediately. | F 371 | ward clerk, or in her absence the administrative manager, will be responsible for checking the box in the nurses' stations for outstanding orders. The completed work orders will be stored by the maintenance director. All employees will be in-serviced on this change by 8/19/16.<br>Monitoring plan to ensure solutions are sustained:<br>Beginning the week of 8/8/16, the Administrator will check the temperature log in both nourishment rooms twice a week for one month, twice a month for three months, once a month for the remainder of the year to ensure that temperatures are being recorded on the log and that any temperatures outside of regulation have been reported to the maintenance department. The results of these audits will be presented at the facility's quarterly quality assurance meetings to ensure ongoing compliance.<br>Beginning the week of 8/22/16, Medical Records will check the copy of the work orders in the nurses' stations to ensure they are being completed correctly and in a timely manner. This check will happen twice a week for two months, once a week for three months, once a month for three months. | |

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| F 371 | Continued From page 34<br><br>An interview was conducted with the Director of Nursing (DON) on 7/13/16 at 5:15 PM. She stated she expected the nourishment refrigerator temperatures to be recorded at a minimum of once per day by nursing staff. She indicated a specific staff person was not designated. She stated she expected to be informed immediately if a temperature was not within normal limits. She indicated she was not informed of any temperatures outside of normal limits until this afternoon (7/13/16).<br><br>A follow up interview was conducted with the DM on 7/14/16 at 7:50 AM. She indicated the nourishment refrigerator utilized for the A, B, and C halls was removed and a new refrigerator was in the process of being purchased.<br><br>A follow up interview was conducted with the DON on 7/14/16 at 8:20 AM. She indicated when staff first recorded a temperature that was outside of normal limits it should have been reported to maintenance immediately and a repair order should have been completed. She stated that items regularly kept in the nourishment refrigerators included: yogurt, gelatin, applesauce, fruit juice, and resident personal food items. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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 | F 431 | | 8/15/16 |

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| F 431 | Continued From page 35<br>controlled drugs is maintained and periodically reconciled.<br><br>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.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to discard expired medications in 2 (A/B and B/C hall medication carts) of 3 medication carts observed. Findings included:<br><br>The facility's policy on " Medication with Special Storage Requirement " dated 6/29/10 was reviewed. The policy for Humalog insulin (used | F 431 | PLAN OF CORRECTION : 483.60 F431<br>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction | |

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| F 431 | Continued From page 36<br>to treat Diabetes Mellitus) read in part " open vials should be labeled with date opened and discarded after 28 days, whether stored in the refrigerator or not. "<br>1. On 7/14/16 at 10:25 AM, the A/B hall medication cart was observed. There was a used Humalog 50/50 kwikpen observed with an open date of 6/11/16 and expiration date of 7/9/16.<br>On 7/14/16 at 10:40 AM, Nurse #5 was interviewed. Nurse #5 observed the used Humalog kwikpen and verified the open date 6/11/16 and expiration date 7/9/16 and stated that the Humalog was already expired and he would discard it.<br>On 7/14/16 at 2:27 PM, the Director of Nursing (DON) was interviewed. The DON stated that nurses were expected to check their medication carts for expired medications daily and the night nurses were expected to check the medication carts for expired medications weekly.<br><br>2. On 7/14/16 at 10:28 AM, the B/C hall medication cart was observed. There was a bottle of GI (gastrointestinal) cocktail with an expiration date of 7/12/16.<br>On 7/14/16 at 10:30 AM, Nurse #6 was interviewed. Nurse #6 acknowledged that the GI cocktail was already expired and she was observed discarding the GI cocktail bottle.<br>On 7/14/16 at 2:27 PM, the Director of Nursing (DON) was interviewed. The DON stated that nurses were expected to check their medication carts for expired medications daily and the night nurses were expected to check the medication carts for expired medications weekly. | F 431 | constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated.<br><br>For the resident affected:<br>No residents were affected. Nurse #5 observed that the Humalog kwikpen was expired and discarded it. Nurse #6 checked the GI cocktail bottle and discarded it because it had expired. Both nurse #5 and nurse #6 were in-serviced on proper storage and expiration dating requirements for Humalog kwikpen and GI cocktail on 07/14/16 by the Director of Nursing.<br><br>For residents that have potential to be affected:<br>All medication carts were checked to ensure all medications met the expiration dating requirements on 7/14/16 by the Resident Care Coordinator. All medication aides and nurses will be in-serviced by the Director of Nursing, Staff Development Coordinator, or Minimum Data Set Coordinator on expiration dating requirements per facility policy by 8/15/16. Nurses that cannot be reached prior to this date will be in-serviced prior to their next scheduled shift.<br><br>System Change:<br>The third shift nurses will check nightly for expired medications. This nightly check will require the third shift nurse to check stock medications, insulins, nebulized solutions, eye drops, inhalers and PRN | |

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| F 431 | Continued From page 37 | F 431 | medications. All newly hired medication aides and nurses will receive training on medication storage and expiration dating requirements per facility policy during orientation.<br><br>Monitoring plan to ensure solutions are sustained:<br>Starting the week of 8/15/15, the Director of Nursing, Staff Development Coordinator, Resident Care Coordinator, or Minimum Data Set nurses will audit each medication cart weekly for one month to ensure storage and expiration dating requirements are met, then each cart twice a month for three months, then once a month for six months. Results will be documented using the Quality Improvement Data Collection Form. Any areas of concern will be addressed immediately. | |