STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility staff and Nurse Practitioner interviews, the facility failed to promptly notify a Nurse Practitioner or	F 157	The NP was notified regarding the malfunctioning of the feeding pump for Resident #2 and changed the order for	11/3/16

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

Electronically Signed | 10/29/2016

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F 157	Continued From page 1 Medical Doctor of the problems encountered with an enteral feeding pump over a 12-hour period for 1 of 1 sampled resident (Resident #2) receiving a continuous tube feeding. The findings included: Resident #2 was admitted to the facility on 10/11/15. Her cumulative diagnoses included status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted). A review of Resident #2 ' s annual Minimum Data Set (MDS) assessment revealed the resident had severely impaired cognitive skills for daily decision making. Resident #2 was assessed to be totally dependent on staff for all of her Activities of Daily Living (ADLs). Section K of the MDS assessment indicated the resident had a feeding tube in place. She received 51% or more of her calories and an average of 501 milliliters (ml) or more of fluid from the feeding tube each day. Section M of the MDS assessment revealed Resident #2 had 3 - Stage 2 pressure ulcers, 1 - Stage 3 pressure ulcer, and one unstageable pressure ulcer with slough or eschar. A review of Resident #2 ' s current physician orders included the following: Osmolite 1.5 (a high calorie, high protein formula used for tube feedings) via gastrostomy tube at 50 ml per hour; 200 ml water flushes via gastrostomy tube every 4 hours; and, 2 packs of Juven (a therapeutic nutritional supplement used to support wound healing) given daily via the gastrostomy tube. Resident #2 did not receive any food or fluids by mouth.	F 157	the feed to bolus feeds. completed: 10/5/16 The continuous feeding pump was replaced and a new order was initiated by the NP for the continuous feed. Completed 10/17/16 Since all residents who have feeding tubes have the potential to be affected by the deficient practice, all identified residents on feeding tubes were reviewed to insure the feeding pumps were functioning correctly and no changes in resident status were noted. Completed 10/19/16 The policy for physician notification was reviewed by the administrator. All nursing staff were in-serviced by the DON on the policy and the requirement to notify the physician of any need for physician intervention, alteration in treatment or to commence a new treatment when a feeding pump malfunctions. 11/3/16 DON/Designee will audit 100% of residents with feeding pumps on each shift to insure the feeding pump is functioning properly and the resident is receiving the correct nutrition. completion: 11/1/16 Any discrepancies will be reported to the physician. The results will be reported to the administrator weekly by the DON. completion: 11/1/16 The DON will insure that a spare pump is available on the unit at all times by maintaining an inventory of pumps and checking the inventory weekly to insure there is a spare pump at all times. completion: 10/28/16 the DON will	

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F 157	Continued From page 2 A review of Resident #2 ' s medical record included a Nurses ' Note dated 10/4/16 at 4:06 AM. The note read: " Kangaroo pump (for G tube, continuous feed) needs to be replaced. The current pump reads "low battery", but when plugged in to charge, it will not pull the current through to charge the machine. The problem is not in the electrical outlet. House Supervisor advised there are no extras on other units. Writer looked on ECU (Extended Care Unit) and Med Surg and no extra ones on either unit. Writer left DON (Director of Nursing) a note in her basket to look into this. " (Authored by Nurse #6) On 10/4/16 at 9:07 AM, Nurse #5 was observed as she prepared medications for administration to Resident #2 via a gastrostomy tube. While the nurse was preparing the medications, two Nursing Assistants (NAs) informed her they had repositioned Resident #2 and noticed the resident ' s enteral feeding pump was off. After the medications were administered to Resident #2, Nurse #5 reported she was going to replace the resident ' s entire feeding set with a different pump as there had been problems with that pump during the night. Accompanied by a second surveyor, an observation was made on 10/4/16 at 9:35 AM of the tube feeding formula container currently hung for Resident #2. A handwritten notation on the Osmolite 1.5 container indicated the formula was hung on 10/3/16 at 9:30 PM. Upon viewing the contents and measurement markings on the container, it was estimated there were approximately 950-975 ml of Osmolite 1.5 formula left in the 1000 ml container. This observation indicated approximately 25-50 ml of	F 157	report the results to the quality assurance and performance improvement committee on a monthly basis for three months and quarterly thereafter for corrective action as necessary. 10/31/16 and ongoing	

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formula had been infused over the previous 12 hours.

An interview was conducted on 10/4/16 at 2:11 PM with Nurse #5. During the interview, the nurse stated she was told there had been a problem with Resident #2 ' s enteral feeding pump in report from the off-going night shift nurse earlier that morning. Nurse #5 also reported she thought the night shift nurse got the pump working and when she started her shift this morning, it did appear to be working. Nurse #5 reported the enteral feeding pump " cut off " when the nursing assistants laid the resident down to provide incontinence care. The nursing assistants reportedly informed Nurse #5 of the situation during the med pass observation.

An interview was conducted on 10/5/16 at 6:55 AM with Nurse #6. Nurse #6 was the nurse assigned to care for Resident #2 from 7:00 PM - 7:00 AM on the night of 10/3/16. During the interview, the nurse recalled hanging the resident's tube feeding formula around 9:30 PM on 10/3/16. She stated that approximately 45 minutes later, the enteral feeding pump started to beep. Nurse #6 reported the green light of the pump was on and the screen read, " Running. " However, the screen also kept flashing a low battery signal. The nurse stated she tried multiple things to get the problem resolved but could not, so requested assistance from Nurse #7. The two nurses again tried multiple interventions without success. Nurse #6 reported she called the facility ' s Director of Nursing (DON) but did not receive a return call from her. The nurses also called the Nursing Supervisor for the hospital, but no one could find a spare enteral feeding pump. Nurse #6 stated she did question

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whether or not the pump was running even though the screen said "Running," so she gave a bolus feed of 50 ml to the resident around 5:30 AM. The nurse confirmed she passed along information about the enteral feeding pump problems in report to the on-coming nurse. When Nurse #6 was told an observation revealed only 25 - 50 ml of the tube feeding formulation hung at 9:30 PM had been infused by 9:35 AM the following morning, the nurse acknowledged the pump must not have been working the night of 10/3/16.

An interview was conducted on 10/5/16 at 7:00 AM with Nursing Assistant (NA) #5. NA #5 was the 3rd shift nursing assistant assigned to care for Resident #2 from 11:00 PM to 7:00 AM on the night of 10/3/16. Upon inquiry, NA #5 recalled making her initial rounds to check on each of her residents around "11'ish (11:00 PM)" that night. The nursing assistant recalled Resident #2 ' s enteral feeding pump screen was blank (off) during rounds. She stated, "I noticed it was off." Upon inquiry, NA #5 stated she did not tell anyone the pump was off because she assumed the nurse was already aware of it. The nursing assistant reported she knew a pump may be shut off for a time on certain occasions if the resident had a bloated stomach, for example. NA #5 reported she did not recall whether or not she looked at the pump later that night.

An interview was conducted on 10/5/16 at 7:05 AM with Nurse #7. Nurse #7 was the second nurse on duty from 7:00 PM - 7:00 AM on the night of 10/3/16. Upon inquiry, the nurse recalled that Nurse #6 had asked her for help with Resident #2 ' s enteral feeding pump around 11:00 PM on 10/3/16. She noted the pump was

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beeping and didn't seem to take a charge even when plugged in. Nurse #7 reported the two nurses went into the room multiple times throughout the night to check on the pump. She recalled the pump's green light was on as if it was charging, but it had a blank screen. Nurse #7 reported the nurses attempted to call the DON and, they called the House Supervisor. Nurse #7 stated she was doubtful at that time whether there would be a spare pump available as she recalled the House Supervisor had been looking for one 3-4 nights ago but could not find a spare. Nurse #7 reported they could not locate a spare enteral feeding pump the night of 10/3/16.

An interview was conducted on 10/5/16 at 11:20 AM with the facility ' s DON. Upon inquiry, the DON recalled having a note tucked under her door when she came in the morning of 10/4/16. The note reported there had been a problem with Resident #2 ' s enteral feeding pump the night of 10/3/16. The DON stated she had understood the pump was going on and off, and reported she was already searching for a replacement pump when Nurse #5 came looking for one that morning. When asked what her expectation was in a situation such as this, the DON stated the nurse should have monitored the feeding throughout the night. If it was determined Resident #2 ' s enteral feeding pump was not working, she would have expected the nursing staff to call a Nurse Practitioner (NP) or Medical Doctor (MD) working in the hospital that night to obtain an order allowing them to provide bolus feeds to Resident #2 until a working pump was located. When asked about the 50 ml bolus feed reportedly given to the resident at 5:30 AM by the nurse, the DON stated, "She can't do that without an order."

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F 157	Continued From page 6 An interview was conducted on 10/5/16 at 12:00 PM with the facility ' s NP. During the interview, the problem encountered with Resident #2 ' s enteral feeding pump the night of 10/3/16 was discussed. Upon inquiry as to when a Nurse Practitioner or Medical Doctor should have been notified of the problem, the NP stated he would have wanted to be notified after 3-4 hours of having problems with the tube feeding so that a bolus feed could have been ordered for the resident. A follow-up telephone interview was conducted on 10/6/16 at 9:11 AM with Nurse #6. Upon inquiry as to whether she notified the NP or MD of Resident #2 ' s enteral feeding pump problem the night of 10/3/16, the nurse stated she did not. Nurse #6 reported she tried to call the NP once around 10:00 PM but did not reach him. She did not leave a message nor did she call him back. The nurse stated she and the other nurse just tried to fix the problem. When asked at what point she felt the NP or MD should have been called back, the nurse stated they should have called at 4:30 AM when they tried to take the battery pack out of the pump. However, she stated they just, "tried to fix the problem. "	F 157		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	F 244		11/3/16

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F 244	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and review of resident council minutes, the facility failed to resolve concerns expressed during the resident council meeting regarding showers not being provided as scheduled. The concerns were documented in 2 of the 3 monthly resident council meetings minutes that were reviewed. The findings included: Review of the Resident Council Meeting minutes of 8/31/16 revealed the residents expressed concerns that showers had not been provided on scheduled shower days and/or on time. The facility ' s written response to the concerns indicated that each resident ' s scheduled shower days would be posted in their room. Review of the Resident Council Meeting minutes of 9/27/16 revealed the residents expressed concern that they were still not receiving showers on their scheduled shower day and/or not at all. The facility ' s written response to the concerns indicated staff should document on the shower sheet when they gave showers to residents and they (residents) could report concerns to the Director of Nursing (DON) when she did her rounds. Resident #59 was admitted to the facility on 1/21/15. The Minimum Data Set (MDS) annual assessment dated 6/29/16, indicated her cognition was intact.	F 244	The bathing/shower schedule and completion per schedule have been reviewed by the DON and baths/showers have been given for affected residents #59 and #95. Since all residents have the potential to be affected by the same deficient practice,the documentation of bathing/showers for all residents was reviewed for completion by the DON and any discrepancies were corrected and bath/showers were provided The policy of addressing grievances and concerns in a group meeting (resident council) was reviewed and updated by the administrator. All department heads will be educated on the policy and procedure for responding to group resident grievances by the administrator. All concerns are to be documented each meeting and sent to the responsible staff member for response and to the administrator for review and follow up. At each council meeting, the previous month□s meeting minutes will be reviewed with the residents by the social worker/activities worker and will include the response to all concerns/grievances from the previous month□s meeting. The resident council minutes along with grievance responses and resolutions resolutions will be reported monthly to the quality assurance and performance	

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F 244	Continued From page 8 During an interview on 10/3/16 at 9:25 AM, Resident #59 reported she did not receive showers or baths on scheduled days of Monday and Thursday. The resident reported she had not received a shower since last Friday (9/30/16). The resident reported she was on the 3rd shift shower list and when she reported it to the DON about not getting showers on her scheduled days, the DON told her she would take care of the concern. The resident reported she did not get the scheduled shower. During a follow-up interview on 10/5/16 at 9:00 AM, Resident #59 stated that she attended the resident council meetings on a regular basis. The residents expressed concerns to the facility about not getting their showers on their scheduled days. The response from the director of nursing and the administrator continued to be " they were working on it " but had not returned back to the group with a response. Resident #59 stated the concerns were expressed a lot in resident council and nothing had changed. On 10/6/16 at 10:45 AM, during a follow-up interview, Resident #59 indicated there were ongoing concerns discussed monthly at the meeting with the activity staff and DON. The DON promised to improve the situation but nothing had changed. Resident #4 was admitted to the facility on 4/15/16. The Minimum Data Set (MDS) quarterly assessment, dated 7/1/16, indicated her cognition was intact. On 10/4/16 at 3:30 PM, during an interview with the resident council president, Resident #4,	F 244	improvement committee by the social worker for review and corrective actions and follow up as necessary.	

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indicated the Resident Council met monthly and discussed an on-going concern of not getting showers regularly and/or on the scheduled shower days. The issue had been discussed for several months and the DON, who participated in the Resident Council Meetings on 8/31/16 and 9/27/16, promised to provide the individual shower schedule to the residents, improve the situation, however, the issue was not resolved.

Resident #95 was admitted to the facility on 6/8/16. The Minimum Data Set (MDS) quarterly assessment, dated 9/1/16, indicated her cognition was intact.

On 10/6/16 at 10:30 AM, during an interview, Resident #95, indicated that she participated in the resident council meetings for the last few months, where she discussed the ongoing issue of not receiving shower on scheduled days. Resident #95 reported she was able to perform some tasks herself with supervision, the main concern had been for other residents that were dependent on staff. The administration promised to improve this situation but no changes occurred for the last two months.

During an interview on 10/5/16 at 12:20 PM, the DON confirmed that Resident #59 and others had reported this concern during the resident council meetings. She could not confirm whether the resident was actually getting the showers. The DON indicated the response form for the resident council was completed this week.

On 10/6/16 at 10:15 AM, during an interview, the activity coordinator stated residents reported during the monthly resident council meeting they were not getting showers as scheduled and/or on

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time. In the July, 2016 the DON was present in the meeting, when the residents verbalized their concern of staff not providing showers. The activity director stated the concern came up again in the August, 2016 meeting and the residents were told by the DON, each person would receive a shower schedule and the situation would improve. The DON attended the September, 2016 meeting and reported that when rounds were being done, the resident could share their concerns with her and showers would be done at residents ' requests.

On 10/6/16 at 10:25 AM, during an interview, the Activity Director indicated that she participated in resident council meetings almost every month and for the last few months she remembered the concerns about not receiving showers on residents ' scheduled days. Monthly, the DON came to the meetings to answer the residents ' concerns. The DON promised to provide the shower schedule for each resident to improve the situation.

During an interview on 10/6/16 at 1:02 PM, the Administrator indicated the activity director was expected to submit the concern forms to the department head following each resident council meeting. The Administrator stated that when individual residents report concerns during the group meeting, the department head should respond to individual concern within 7 days. Additional, group concerns would be responded to within 30 days. The administrator indicated the department heads should submit the form back to the activity director for discussion at the next meeting.

On 10/6/16 at 3:45 PM, during an interview, the

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F 244	Continued From page 11 DON, stated that she was aware of the residents concern of not getting their showers. She confirmed participating in the resident council meetings for the last few months. The DON responded to the residents that she would continue to make rounds and was open for any concerns they had. She distributed and posted the individual shower schedules in each room. Also, the DON rearranged the staff on the floor to improve the situation with all activities of daily living.	F 244		
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 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. 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). This REQUIREMENT is not met as evidenced by:	F 279		11/3/16

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F 279	Continued From page 12 Based on medical record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of --22 sampled residents (Resident #38) whose care plans were reviewed. The findings included: Resident #38 was admitted to the facility on 4/29/16 from an acute care hospital. Her cumulative diagnoses included a recent fall with a right hip fracture. A review of Resident #38's admission MDS (Minimum Data Set) assessment dated 5/6/16 revealed the following care areas were triggered for an analysis of the findings: Urinary Incontinence and Indwelling Catheter; Falls; Nutritional Status; Dehydration/Fluid Maintenance; Pressure Ulcer; and, Pain. A Care Area Assessment (CAA) Worksheet was completed for each of the care areas triggered. A review of the CAA Worksheets revealed the care areas related to Urinary Incontinence and Indwelling Catheter; Falls; Pressure Ulcer; and, Pain would be addressed in the resident's care plan. A review of Resident #38's Care Plan (initiated on 8/1/16; revised on 8/25/16) revealed only one area of focus addressing Nutrition was in place. A comprehensive care plan addressing each of the care areas triggered by the MDS (with a decision to proceed to care planning) was not available. A review of Resident #38's most recent quarterly MDS (Minimum Data Set) assessment dated 8/26/16 revealed the resident had severely	F 279	The comprehensive care plan for resident #38 was reviewed for all triggered areas and updated as necessary by the MDS coordinator. completed: 10/6/16 Since all residents have the potential to be affected by the same deficient practice,each resident will be reviewed by the MDS Coordinator to insure that each care area triggered has a care plan in place. Completion: 11/3/16 The policy and procedure for care plan completion was reviewed by the administrator and director of nursing. The MDS coordinator was re educated on completion of care plans by the administrator. Completed: 10/10/16 The DON/designee will audit the completion of 100% of care plans for all areas triggered in the care area assessment on a weekly basis. Completion: 11/3/16 The absence of a care plan will be corrected at the time of audit. The DON will submit the audit results administrator on a weekly basis for review and monthly to the quality assurance and performance Improvement committee for three months and quarterly thereafter for review and corrective action as necessary. Completion: 11/3/16	

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impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with bed mobility and supervision with eating.

An interview was conducted on 10/6/16 at 10:10 AM with the facility ' s MDS Coordinator. Upon review of the Resident #38's Care Plan, the MDS Coordinator acknowledged there was only one focus area addressed (Nutrition). "I don't know what happened to it (the rest of the Care Plan)." She reported she would have to put the Care Plan back into the electronic record. The MDS Coordinator stated, "I can't explain why it's not there...I don't know."

An interview was conducted on 10/6/16 at 3:43 PM with the facility's Director of Nursing (DON). During the interview, the DON indicated she would expect all residents to have a comprehensive Care Plan in place.

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Based on record review, staff and resident interviews, the facility failed to develop a comprehensive care plan for 1 of 3 sampled residents (Resident #52) reviewed for receiving assistance with activity of daily living (ADL) and psychotropic medications.
The findings included:
Resident #52 was admitted to the facility on 5/3/16. Review of the resident ' s admission Minimum Data Set assessment, dated 5/10/16, revealed she was moderately cognitively impaired. The resident ' s diagnoses included dementia, anxiety, hydrocephaly (brain fluid accumulation with brain damage), VP shunt

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(surgically inserted devise to drain extra fluid from the brain in to the abdomen), altered mental status and history of fall. She required supervision with eating and bed mobility, extensive assistance for transfer and toileting. The resident received antidepressant, antianxiety medications and diuretic seven days a week. She was always continent for bladder and bowel.
Review of Resident 52 ' s Care Area Assessment (CAA), dated 5/10/16, revealed triggered care areas as incontinence, falls, nutritional status, pressure ulcer and psychotropic drug use. None of the triggered areas in CAA were indicated as addressed in care plan.
There was no plan of care initiated at admission in May 2016. Review of Resident 52 ' s plan of care, dated on 8/16/16, revealed the resident received a therapeutic diet. There was no other plan of care available for review at the time of investigation.

Record review of Resident 52 ' s care tracker for September-October 2016 revealed that resident received assistance with toileting, transfer, dressing and bathing every day.
Review of Resident 52 ' s medication administration record (MAR) for the month of May - August 2016 revealed that the MAR reflected physician ' s orders to receive psychotropic medications including Celexa, an antidepressant and Buspirone, an antianxiety medication.

On 10/4/16 at 10:30 AM, during an interview, Resident #52 confirmed that she needed assistance with ADLs and received assistance from the staff every day.
On 10/6/16 at 11:30 AM, during an interview, Nurse Aide #1 stated that she provided different levels of assistance with ADLs to Resident #52

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F 279	Continued From page 15 daily. The resident could partly participate in ADLs, but the nurse aide had to complete the tasks. On 10/06/2016 at 2:39 PM, during an interview, the MDS coordinator indicated that the nurses on the floor were supposed to do the comprehensive care plan. The MDS coordinator based her care plans on the assessment tools, interviews, MAR, physician ' s orders, progress notes and information, written by the nurses and aides. The nurses were also responsible to update care plans with interventions. On 10/6/16 at 2:55 PM, during an interview, Nurse #1 stated that Resident #52 required different levels of ADLs assistance. She was diagnosed with anxiety and dementia, had an altered mental status, memory issues, became confused at times and received scheduled psychotropic medications. On 10/6/16 at 3:45 PM, during an interview, the Director of Nursing (DON) stated that it was her expectation for the staff to create care plans for all the areas triggered in the Care Area Assessment. She indicated that the MDS nurse was responsible for development of the comprehensive plan of care. The DON was not aware that Resident 52 ' s care plan covered only one area of the resident ' s needs.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		11/3/16

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F 312	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview and review of record, the facility failed to provide showers and shaving for 2 of 6 residents dependent upon staff for activities of daily living (ADL) assistance (Resident #59 and #19). The findings included 1.Resident #59 was admitted facility on 1/21/15. The cumulative diagnoses included chronic kidney disease, rheumatoid arthritis, muscle weakness and spinal stenosis of lumbar region. The Minimum Data Set (MDS) dated 6/29/16, indicated the resident ' s cognition was intact and she required extensive assistance with all activities of daily living, supervision with bathing, transfers and mobility. Review of the care plan dated 6/29/16, identified the problem as: resident had activities of daily living deficits related to arthritis, hypertension and pain. The goal included resident would maintain current level of function in all activities of daily living. The approaches included the resident ' s preference of a sponge bath when full bath or shower could not be tolerated, checking cleaning and trimming nails during bath day, and completing dressing and grooming in the morning. The resident needed supervision and limited assistance with transfers. Review of Resident #59 ' s bath/shower sheets and ADL care tracker sheet 8/18/16 through 10/5/16, revealed that scheduled showers were randomly being done and there was no consistent means of tracking when they were actually being done. During an interview on 10/3/16 at 9:25 AM,	F 312	The bath/shower schedule for resident #59 was reviewed and changed to day shift and the resident is receiving her bath/shower as confirmed by staff interview. The preference for a daily shave by resident #19 was documented in the resident□s care plan and implemented to insure the resident is shaved daily. Since all residents have the potential to be impacted by the same deficient practice, the bath/shower/shaving schedule and documentation was reviewed by the DON for each resident and any discrepancies addressed. Each resident requiring shaving will be asked what their preference is in regards to frequency of shaving by the MDS Coordinator and was documented in the care plan by the MDS coordinator. completion: 10/10/16 The policy for resident bath/shower and ADL care was reviewed by the Administrator. Completion: 10/9/16 A form was developed for CNA's to document the bath/shower/shaving activity based on the resident□s schedule. All CNA's were educated on the policy and form by the DON. Completion: 11/3/16 The DON/designee will report the compliance results from the shower/bath/shaving form on 100% of all resident□s bath/showers/shaving and a	

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F 312	Continued From page 17 Resident #59 reported she did not receive showers or baths on scheduled days of Monday and Thursday. The resident stated her preference was to receive a shower or bath daily and that she had spoken with the Administrator and Director of Nursing (DON) about her concerns of not getting the shower on her scheduled days. Resident #59 indicated that when there was a staff shortage she received a shower once a week. The resident reported she had not received a shower since last Friday (9/30/16). She added that when staff reported they were short of staff and the shower would not be given " it was upsetting and my skin would feel itchy and I did not want to be sitting around stinky. " She ended up waiting toward the end of the week to get a shower and attempted to do the best she could with washing herself up the other days. The resident reported she was on the 3rd shift shower list and when she reported it to the DON about not getting showers on her scheduled days, DON told her she would take care of the concern. The resident reported she did not get the scheduled shower. During a follow-up interview on 10/5/16 at 9:00 AM, Resident #59 stated that she attended the resident council meetings on a regular basis. The residents expressed concerns to the facility about not getting their shower on their scheduled days and the shortage of staff. The response from the Director of Nursing and the Administrator continued to be " they were working on it " but had not returned back to the group with a response. The nursing assistants continued to report there were not enough staff to give everyone their showers on scheduled days and this was reported to the director of nursing during the council meeting. Resident #59 stated the	F 312	random sample of resident validation. Completion: 10/12/16 Results will be submitted each week to the administrator and monthly for three months and quarterly thereafter to the Quality Assurance and Performance Improvement Committee for review and corrective action as necessary. Completion: 10/31/16 and on-going	

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concerns had been talked about a lot in resident council and nothing had changed.

During an interview on 10/5/15 at 12:20 PM, the DON indicated she was aware of Resident #59 ' s concerns about not getting showers on scheduled days as well as her preference for more showers. The DON also confirmed that Resident #59 and others had reported this concern during the resident council meetings. She could not confirm whether the resident was actually getting the showers.

During an interview on 10/5/16 at 1:40 PM, Nursing Assistant (NA) #1 indicated that showers were not consistently being done due to shortage of staff and other responsibilities. The expectation was to complete the NA shower/skin observation tool when the shower was done. If there was no sheet then it may not have been done.

During an interview on 10/5/16 at 1:45 PM, NA #4 indicated that many of the basic care task were done to the best of his ability due to lack of staffing. Sometimes there were only two NAs to perform all the task for the residents. The NA reported residents had complained about not getting scheduled showers, but we do what we can. If there was no NA shower sheet it may not have been done.

During an interview on 10/6/16 at 9:40 AM, Resident #59 indicated that there was only 1 nurse and 1 NA on duty last night and she was told that 1st shift would give her the shower because there was not enough staff early this morning.

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During a telephone interview on 10/6/16 at 9:42 AM, Nurse #6 stated that Resident #59 did receive a shower on Wednesday morning as per the DON. The DON stated in the presence of Resident #59 that a shower would be given two nights a week on 3rd shift.

During an follow-up interview on 10/6/16 at 10:04 AM, the DON reviewed the ADL tracker form 8/18/16 through 10/5/16, for bathing and confirmed there were long periods of time the resident did not receive a shower/bath. The DON stated Resident #59 was designated for 3rd shift showers and the NA documentation criteria meant that it was not done for those days.

2. Resident #19 was admitted to the facility on 11/16/12 from an acute care hospital. His cumulative diagnoses included hemiplegia (paralysis of one side of the body).

A review of Resident #19 ' s most recent quarterly MDS (Minimum Data Set) assessment dated 9/19/16 revealed he had intact cognitive skills for daily decision making. The resident was noted to have unclear speech but did have the ability to express ideas and wants. He was assessed to understand verbal content and was reported as usually being understood. No behaviors nor rejection of care were noted. Resident #19 required varying levels of assistance for his Activities of Daily Living (ADLs). The resident was assessed as being totally dependent on staff for toileting and requiring extensive assistance for bed mobility, limited assistance for transfers and dressing, set-up help for eating, and supervision

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for personal hygiene.

A review of Resident #19 ' s Care Plan included, in part:
Area of Focus: The resident has an ADL self-care performance deficit related to a history of cerebrovascular accident (stroke) with right side hemiparesis (initiated 8/13/14; revised on 7/14/16).
The interventions included:
-- " Bathing/showering: The resident is totally dependent on staff to provide bath/shower twice weekly and as necessary ...
--Personal hygiene: The resident requires (extensive assistance) by (1) staff with personal hygiene and oral care ... "

An observation made on 10/3/16 (Sunday) at 2:30 PM revealed Resident #19 had approximately 1/8 " curly facial hair. Upon inquiry, the resident stated he could not shave himself and required assistance from staff for this task. The resident reported he was shaved on his shower days, which were scheduled twice a week. However, Resident #19 reported he wanted to be shaved every day and liked to be clean shaven. When asked if he had told staff he wanted to be shaved every day, the resident reported that he had. However, he indicated staff did not have time to shave him every day.

An observation made on 10/4/16 (Monday) at 9:00 AM revealed the resident had approximately 1/8" curly facial hair. The resident appeared to be unshaven.

An observation conducted on 10/5/16 (Tuesday) at 9:35 AM revealed Resident #19 had curly facial hair approximately 1/8" long. The resident

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appeared to be unshaven.

An observation and interview were conducted on 10/5/16 at 2:02 PM with Resident #19. At the time of the interview, the resident was observed to have curly facial hair approximately 1/8" long. The resident confirmed he would like to be shaved daily.

An interview was conducted on 10/5/16 at 2:10 PM with Nursing Assistant (NA) #4. NA #4 typically worked on the 1st shift and was assigned to care for Resident #19. During the interview, NA #4 reported Resident #19 was a reliable historian and could nod/shake his head and reliably verbalize some answers to questions posed. NA #4 reported he last shaved Resident #19 on Sunday (10/3/16). NA #4 stated he was not aware the resident wanted to be shaved every day.

An interview was conducted on 10/6/16 at 9:58 AM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected male residents to be shaved, " Every day with their AM (morning) care. " She added that if a male resident was not able to request otherwise, he would be shaved every day.

An observation was made of Resident #19 on 10/6/16 at 11:45 AM sitting in his wheelchair in the Activity Room. The resident appeared to have been recently shaved; no facial hair was observed.

An interview was conducted on 10/6/16 at 4:34 PM with Resident #19. Upon inquiry as to how he felt after being shaved, the resident smiled and stated, "Good."

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to apply splints as ordered by the physician for 1 of 1 sampled residents with contracture (Resident #1). The findings included: Resident #1 was admitted to the facility on 12/15/09. The cumulative diagnoses included dementia, osteoporosis and bilateral contractures of hands. The Minimum Data Set (MDS) assessment dated 6/2/16, indicated Resident #1 was non-verbal and cognitively impaired. Resident #1 required total assistance with all activities of daily living and was coded with contractures of both hands. Review of the physician order dated 12/4/15, revealed that bilateral hand splints (palm) should be applied every morning 8AM and removed every evening 8PM. Review of the treatment administration record (TAR) revealed the time when nursing staff was expected sign on and off that the splint was applied as 8 AM and off at 8 PM. The nurses documented on the TAR that the bilateral hand splints (palm) were applied 11 of 31 days for the	F 318	Occupational therapy will re-assess resident #1 to insure the appropriate device for range of motion care is in place. The order for a device will be updated if necessary. The MDS coordinator will update the care plan if necessary. Since all residents who have orders for splints have the potential to be affected by the deficient practice, all residents with current orders for splints will be reviewed by the DON to insure that the splints are being applied as per physician order and care planned. Any discrepancies in application will be corrected. The policy for splints and braces will be reviewed and updated. All CNA□s and restorative aides will be educated on following the care plan for applying and removing splints. All nurses will be educated on documenting on the TAR the splint application. Director of Therapy will maintain an updated listing of all residents with splints.	11/3/16

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F 318	Continued From page 23 month of July 2016, 16 of 31 days in August 2016, and 21 of 30 days in September 2016. There were several days on the TAR that were left blank at 8 AM for July 2016 was 19, 15 days in August 2016 and 12 days in September 2016. Review of the care plan dated 6/7/16, identified the problem as: the resident had activities of daily living (ADL) deficit related to hemiplegia, contractures, aphasia, late effects intracranial injury, and long term disability. The goal included resident ADLs would be identified and met by staff. The approaches included resident was totally dependent on staff for repositioning and turning in bed every 2 hours and as necessary and apply splint and brace per physician ' s order. Review of physician order dated 9/8/16, revealed an order for the resident to have an occupational therapy evaluation, wear bilateral hand splints in the morning and to remove them in the evening, and to continue restorative nursing program. During an observation on 10/3/16 at 10:45AM, Resident#1 had bilateral contractures of hands. There were no palm splints in place. The palm splints were located on the sink and the other one on the night stand next to a blue wedge cushion. During an observation on 10/3/16 at 2:45PM, Resident #1 remained in bed without the palm splints in place. The palm splints remained on the sink and the other one night stand next to the wedge cushion. During an interview on 10/5/16 at 1:40 PM, Nursing Assistant (NA) #1 stated splint applications had not been consistently done due to short of NA staff.	F 318	An audit will be conducted by the DON/Designee of 100% of residents with splints/devices on a weekly basis and reported to the administrator with audit results being submitted to the quality assurance and performance improvement committee monthly for three months and quarterly thereafter for review and corrective action as necessary.	

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During an interview on 10/5/16 at 1:45 PM, NA#4 stated that splint application had not been consistently done due to shortage of NA staff on a shift. NA#4 indicated at times there were only two NA ' s to provide care for all the residents.

During an interview on 10/5/16 at 2:10 PM, Rehabilitation Director indicated that once the residents were discharged from the therapy department and referred to the restorative program it was the responsibility of nursing to ensure the application of splints were being done.

During an interview on 10/5/16 at 5:08 PM, Nurse #1 indicated the nursing assistants were responsible for applying the splints, and nurses were responsible for monitoring and documenting that the splints were applied on the treatment record.

During an interview on 10/6/16 at 10:04AM, the DON stated that she was newly hired and she was unaware there was a restorative program in place. The DON stated her expectation was for the nursing assistants to apply the splints during care and the nurse to document the splint application on the TAR. The DON reviewed the TAR for 3 months and confirmed the documentation of splint application was inconsistent and/or had not been done.

During an interview on 10/6/16 at 1:02PM, the Administrator indicated the nursing assistants were responsible for splint application and the nurse was responsible for monitoring and ensuring the splints were being applied and documented.

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F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a continuous tube feeding as ordered for 1 of 1 sampled resident (Resident #2) receiving a tube feeding. The findings included: Resident #2 was admitted to the facility on 10/11/15. Her cumulative diagnoses included status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted).	F 322	An order was initiated for bolus feeds for resident #2 until a new feeding pump was in place. completion: 10/6/16 Feeding pump replaced and functioning without interruption. Completion 10/17/16 Since all residents on an enteral feeding pump have the potential to be affected by the deficient practice, all residents on an enteral pump were identified and all pumps were checked by DON to insure the pumps were working properly. completed: 10/19/16	11/3/16

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F 322	Continued From page 26 A review of Resident #2 ' s annual Minimum Data Set (MDS) assessment revealed the resident had severely impaired cognitive skills for daily decision making. Resident #2 was assessed to be totally dependent on staff for all of her Activities of Daily Living (ADLs). Section K of the MDS assessment indicated the resident had a feeding tube in place. She received 51% or more of her calories and an average of 501 milliliters (ml) or more of fluid from the feeding tube each day. The resident ' s weight was noted to be 163 pounds (#). Section M of the MDS assessment revealed Resident #2 had 3 - Stage 2 pressure ulcers, 1 - Stage 3 pressure ulcer, and one unstageable pressure ulcer with slough or eschar. A review of Resident #2 ' s current physician orders included the following: Osmolite 1.5 (a high calorie, high protein formula used for tube feedings) via gastrostomy tube at 50 ml per hour; 200 ml water flushes via gastrostomy tube every 4 hours; and, 2 packs of Juven (a therapeutic nutritional supplement used to support wound healing) given daily via the gastrostomy tube. Resident #2 did not receive any food or fluids by mouth. A review of Resident #2 ' s Care Area Assessment (CAA) Worksheet for Nutritional Status (dated 9/20/16) revealed the resident ' s nutritional status would be addressed in her care plan. The care plan considerations included a notation by the facility ' s Registered Dietitian (RD) which read: " BMI (body mass index) is 25.6 which is overweight, but is considered normal for age. Pt (patient) is with several new pressure ulcers as of 9/14 ... " A review of the resident ' s Care Area Assessment (CAA)	F 322	The policy for enteral feedings/continuous tube feeding was reviewed by the DON/designee. Completed 10/10/16. All nursing staff were educated the importance of checking the pumps on each shift to insure the pump is properly working. Any irregularities are to be reported to the charge nurse immediately for pump replacement. completion: 11/3/16 The DON/designee will insure that spare working pumps are available in inventory at all times by doing an inventory of pumps weekly. completion: 10/28/16 DON/designee will check to see that all pumps are functioning properly for 100% residents on continuous feed with pumps weekly and make any corrections as necessary. Completion: 10/28/16 The audit results will be reported to the administrator weekly and to the quality assurance and performance improvement committee monthly for three months and quarterly thereafter for review and corrective action as necessary. completion: 11/3/16	

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Worksheet for a Feeding Tube (dated 10/4/16) revealed the feeding tube would also be addressed in her care plan.

A review of Resident #2 ' s care plans included the following:
--The resident requires tube feeding related to dysphagia (difficulty with swallowing)--initiated on 10/26/15;
--The resident has a swallowing problem related to swallowing assessment results. Requires enteral feeding--initiated 10/19/15.

A review of Resident #2 ' s medical record included a Nurses ' Note dated 10/4/16 at 4:06 AM. The note read:
" Kangaroo pump (for G tube, continuous feed) needs to be replaced. The current pump reads "low battery", but when plugged in to charge, it will not pull the current through to charge the machine. The problem is not in the electrical outlet. House Supervisor advised there are no extras on other units. Writer looked on ECU (Extended Care Unit) and Med Surg and no extra ones on either unit. Writer left DON (Director of Nursing) a note in her basket to look into this. " (Authored by Nurse #6)

On 10/4/16 at 9:07 AM, Nurse #5 was observed as she prepared medications for administration to Resident #2 via a gastrostomy tube. While the nurse was preparing the medications, two Nursing Assistants (NAs) informed her they had repositioned Resident #2 and noticed the resident ' s enteral feeding pump was off. After the medications were administered to Resident #2, Nurse #5 reported she was going to replace the resident ' s entire feeding set with a different pump as there had been problems with that pump

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during the night.

Accompanied by a second surveyor, an observation was made on 10/4/16 at 9:35 AM of the tube feeding formula container currently hung for Resident #2. A handwritten notation on the Osmolite 1.5 container indicated the formula was hung on 10/3/16 at 9:30 PM. Upon viewing the contents and measurement markings on the container, it was estimated there were approximately 950-975 ml of Osmolite 1.5 formula left in the 1000 ml container. This observation indicated approximately 25-50 ml of formula had been infused over the previous 12 hours.

A review of Resident #2 ' s medical record revealed her weight on 10/4/16 = 150.0#.

An interview was conducted on 10/4/16 at 2:11 PM with Nurse #5. During the interview, the nurse stated she was told there had been a problem with Resident #2 ' s enteral feeding pump in report from the off-going night shift nurse earlier that morning. Nurse #5 also reported she thought the night shift nurse got the pump working and when she started her shift this morning, it did appear to be working. Nurse #5 reported the enteral feeding pump " cut off " when the nursing assistants laid the resident down to provide incontinence care. The nursing assistants reportedly informed Nurse #5 of the situation during the med pass observation.

An interview was conducted on 10/5/16 at 6:55 AM with Nurse #6. Nurse #6 was the nurse assigned to care for Resident #2 from 7:00 PM - 7:00 AM on the night of 10/3/16. During the interview, the nurse recalled hanging the

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resident's tube feeding formula around 9:30 PM on 10/3/16. She stated that approximately 45 minutes later, the enteral feeding pump started to beep. Nurse #6 reported the green light of the pump was on and the screen read, " Running. " However, the screen also kept flashing a low battery signal. The nurse stated she tried multiple things to get the problem resolved but could not, so requested assistance from Nurse #7. The two nurses again tried multiple interventions without success. Nurse #6 reported she called the facility ' s Director of Nursing (DON) but did not receive a return call from her. The nurses also called the Nursing Supervisor for the hospital, but no one could find a spare enteral feeding pump. Nurse #6 stated she did question whether or not the pump was running even though the screen said "Running," so she gave a bolus feed of 50 ml to the resident around 5:30 AM. The nurse confirmed she passed along information about the enteral feeding pump problems in report to the on-coming nurse. When Nurse #6 was told an observation revealed only 25 - 50 ml of the tube feeding formulation hung at 9:30 PM had been infused by 9:35 AM the following morning, the nurse acknowledged the pump must not have been working the night of 10/3/16.

An interview was conducted on 10/5/16 at 7:00 AM with Nursing Assistant (NA) #5. NA #5 was the 3rd shift nursing assistant assigned to care for Resident #2 from 11:00 PM to 7:00 AM on the night of 10/3/16. Upon inquiry, NA #5 recalled making her initial rounds to check on each of her residents around "11'ish (11:00 PM)" that night. The nursing assistant recalled Resident #2 ' s enteral feeding pump screen was blank (off) during rounds. She stated, "I noticed it was off."

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Upon inquiry, NA #5 stated she did not tell anyone the pump was off because she assumed the nurse was already aware of it. The nursing assistant reported she knew a pump may be shut off on certain occasions if the resident had a bloated stomach, for example. NA #5 reported she did not recall whether or not she looked at the pump later that night.

An interview was conducted on 10/5/16 at 7:05 AM with Nurse #7. Nurse #7 was the second nurse on duty from 7:00 PM - 7:00 AM on the night of 10/3/16. Upon inquiry, the nurse recalled that Nurse #6 had asked her for help with Resident #2 ' s enteral feeding pump around 11:00 PM on 10/3/16. She noted the pump was beeping and didn't seem to take a charge even when plugged in. Nurse #7 reported the two nurses went into the room multiple times throughout the night to check on the pump. She recalled the pump's green light was on as if it was charging, but it had a blank screen. Nurse #7 reported the nurses attempted to call the DON and, they called the House Supervisor. Nurse #7 stated she was doubtful at that time whether there would be a spare pump available as she recalled the House Supervisor had been looking for one 3-4 nights ago but could not find a spare. Nurse #7 reported they could not locate a spare enteral feeding pump the night of 10/3/16.

An interview was conducted on 10/5/16 at 11:20 AM with the facility ' s DON. Upon inquiry, the DON recalled having a note tucked under her door when she came in the morning of 10/4/16. The note reported there had been a problem with Resident #2 ' s enteral feeding pump the night of 10/3/16. The DON stated she had understood the pump was going on and off, and reported she

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F 322	Continued From page 31 was already searching for a replacement pump when Nurse #5 came looking for one that morning. When asked what her expectation was in a situation such as this, the DON stated the nurse should have monitored the feeding throughout the night. If it was determined Resident #2 ' s enteral feeding pump was not working, she would have expected the nursing staff to call a Nurse Practitioner (NP) or Medical Doctor (MD) working in the hospital that night to obtain an order allowing them to provide bolus feeds to Resident #2 until a working pump was located. When asked about the 50 ml bolus feed reportedly given to the resident at 5:30 AM by the nurse, the DON stated, "She can't do that without an order." An interview was conducted on 10/5/16 at 12:00 PM with the facility ' s NP. During the interview, the problem encountered with Resident #2 ' s enteral feeding pump the night of 10/3/16 was discussed. Upon inquiry as to when a Nurse Practitioner or Medical Doctor should have been notified of the problem, the NP stated he would have wanted to be notified after 3-4 hours of having problems with the tube feeding so that a bolus feed could have been ordered for the resident.	F 322		
F 329 SS=D	483.25(l) 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	F 329		11/3/16

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F 329	Continued From page 32 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 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess the presence and severity of involuntary movements due to the use of antipsychotic medications for 1 of 5 sampled residents (Resident #41) reviewed for unnecessary medications. The findings included: Resident #41 was admitted to the facility on 10/20/15 from the community. Her cumulative diagnoses included schizophrenia. A review of the resident's medical record revealed her current medications included, in part: 10 milligrams (mg) fluphenazine (a first generation antipsychotic medication) initiated on 10/20/15 with instructions to give 3 tablets by mouth every	F 329	The AIMS form was completed for resident #41 by the MDS coordinator. completion: 10/6/16 The record of all residents who are prescribed antipsychotic drugs will be reviewed by the pharmacy consultant to verify that the AIMS assessment was completed as required. All residents reviewed had AIMS assessments completed. Completion: 10/13/16 The policy on AIMS assessment requirements was reviewed and updated by DON. Completion: 10/25/16 All nursing staff were educated on their responsibility to complete the AIMS assessment every six months as per	

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F 329	Continued From page 33 night at bedtime; and, 15 milligrams (mg) aripiprazole (a second generation antipsychotic medication) initiated on 12/7/15 with instructions to give 1 tablet by mouth once daily. Resident #41's most recent quarterly Minimum Data Set (MDS) assessment dated 7/11/16 revealed the resident had moderately impaired cognitive skills for daily decision making. She was assessed as requiring extensive assistance from staff for bed mobility; limited assistance for transfers, dressing and toileting; and, supervision for eating and personal hygiene. Section N of the MDS assessment revealed the resident received antipsychotic medication(s) on 7 out of 7 days during the look back period. A review of the resident's current Care Plan included, in part: Area of focus: The resident uses psychotropic medications related to schizophrenia (initiated 11/3/15). Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Further review of the resident's medical record revealed there was no documentation of an assessment having been completed for the presence and severity of involuntary movements due to the use of antipsychotic medications. Neither the paper nor electronic medical record for Resident #41 contained the results of an Abnormal Involuntary Movements Scale (AIMS) assessment.	F 329	policy and procedure by the Pharmacy and the DON. completed: 11/3/16 The DON/designee will review those residents on antipsychotic will review all residents on antipsychotic medications every month to monitor that the AIM assessment has been completed as required. completion: 11/3/16 The pharmacy will continue to review the completion of the AIMS assessment for residents on antipsychotic medications every month and report findings to the DON. completion: 10/13/16 ongoing. The DON will report the results of the AIMS review to the quality assurance and performance improvement committee monthly for three months. The pharmacy will report on compliance with the AIMS assessment on a quarterly basis thereafter for correction action as necessary. completion: 11/3/16 and on-going	

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F 329	Continued From page 34 A telephone interview was conducted on 10/6/16 at 3:20 PM with the facility's consultant pharmacist. Upon inquiry as to when Resident #41 had an AIMS assessment completed, the pharmacist reported she would review Resident #41's pharmacy records and return the call. An interview was conducted on 10/6/16 at 3:43 PM with the facility's Director of Nursing (DON). When asked, the DON stated she expected an AIMS assessment to be done quarterly for residents receiving an antipsychotic medication. During the interview with the DON, the DON received a telephone call from the facility's consultant pharmacist. After talking with the consultant pharmacist on the telephone, the DON reported it was determined that an AIMS assessment had not been completed for Resident #41 since her admission to the facility. A follow-up telephone interview was conducted on 10/6/16 at 3:54 PM with the consultant pharmacist. Upon reviewing Resident #41's records, the pharmacist confirmed no AIMS assessments had been completed since the resident ' s admission to the facility. The consultant pharmacist reported she had made repeated requests on her Pharmacist Consultation Reports for AIMS testing to be done for this resident. The pharmacist stated she would expect an AIMS assessment to be completed for any resident receiving an antipsychotic medication upon admission to the facility (as a baseline) and at least every 6 months thereafter.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		11/3/16

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F 332	Continued From page 35 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.1%, for 1 of 5 residents (Resident #2) observed during medication pass. The findings included: 1) A review of the facility's policy, Medication Administered through an Enteral Tube (revised 10/14), included the following procedural guidelines, in part: "5. Administer each medication separately and flush the tubing between each medication. a. Flush with at least 15 ml (milliliters) of water after each individual medication is given. b. For a resident who requires fluid regulation, the physician's order should include the amount of water to be used for the flushing and administration of medications. c. Finely crush medications only in accordance with manufacturer's recommendations. d. Enteric coated medications and long acting medication formulations should not be administered through an enteral tube. e. Consult the prescriber and pharmacist for alternative formulations and doses." Resident #2 was admitted to the facility on 10/11/15. Her cumulative diagnoses included	F 332	Nurse #5 who administered the medications for resident #2 was educated by the DON on the requirement that each medication be administered separately and the tube flushed between each medication in the policy, Medication Administered through an Enteral Tube as well as enteric coated medication should not be crushed and administered through a feeding tube. Completed: 10/5/16 Every resident who is on enteral feeding could be affected by the deficient practice. All residents on enteral feeding were reviewed, completed:10/19/16 and all nurses will be educated on the policy of medication administration for residents on an enteral tube by the DON/Pharmacy on the requirement that each medication be administered separately and the tube flushed between each medication and that enteric coated medication can not be crushed and administered through a feeding tube. competed 11/3/16 The policy for Medication Administration through an Enteral Tube was reviewed by the DON. completed: 10/10/16 All nursing staff will be educated on the policy and the requirement to administer medications separately and to flush the tube between each medication.	

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F 332	Continued From page 36 status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted). A review of Resident #2's physician orders included the following medications, in part: 81 milligram (mg) chewable aspirin to be given as one tablet via tube every day; 5 mg amlodipine (a blood pressure medication) to be given as one tablet via tube every day; and, 20 mg lisinopril (a blood pressure medication) to be given as one tablet via tube every day. On 10/4/16 at 9:07 AM, Nurse #5 was observed as she prepared medications for administration to Resident #2 via a gastrostomy tube. The nurse placed the following medications into a medication cup: one-81 mg enteric coated aspirin; one-5 mg amlodipine tablet; and, one-20 mg lisinopril tablet. Nurse #5 was observed as she crushed the three medications together and added approximately 20 ml of water to the combined crushed medications. The nurse flushed Resident #2's gastrostomy tube with 40 ml of water using a syringe, then administered the crushed medications mixed with water via the gastrostomy tube. After administering the medications, Nurse #5 flushed the gastrostomy tube with approximately 50 ml of water. An interview was conducted on 10/4/16 at 2:11 PM with Nurse #5. Upon inquiry, the nurse acknowledged Resident #2's medications were crushed and administered together via gastrostomy tube during the medication pass observation. The nurse reported Resident #2's medications were always administered in this way. Nurse #5 stated she was not aware medications needed to be administered	F 332	completion: 11/3/16 DON/designee will conduct 10 medication pass observations on medication administration for residents who are on enteral tube feeding weekly on the all shifts and on random days of the week and report the results to the administrator. Completion: 11/3/16 and ongoing The observation results will be reported to the Quality Assurance and Performance Improvement committee monthly for three months and quarterly thereafter for review and correction action as necessary. completion: 11/3/16	

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separately when given via a gastrostomy tube.

An interview was conducted on 10/5/16 at 11:00 AM with the facility's consultant pharmacist. During the interview, the pharmacist stated she would expect medications administered via a gastrostomy tube to be crushed separately and administered separately to the resident. The pharmacist stated the facility would need to set up in-service training for the nursing staff to provide education and reinforcement for the administration of medications via gastrostomy tube.

An interview was conducted on 10/5/16 at 11:10 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect medications to be crushed one at a time, and water flushes provided between each medication administered via gastrostomy tube.

2) A review of the facility's policy, General Dose Preparation and Medication Administration (dated 1/1/13) included the following procedural guideline, in part:
"3.8 Facility staff should crush oral medications only in accordance with Pharmacy guidelines as set forth in Appendix 16: Common Oral Dosage Forms that Should Not Be Crushed and/or Facility policy."
Appendix 16 included enteric coated aspirin as one of the medications that should not be crushed and indicated the reason as "Delayed release."

A review of the facility's policy, Medication Administered through an Enteral Tube (revised 10/14), included the following procedural guideline, in part:

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"5. d. Enteric coated medications and long acting medication formulations should not be administered through an enteral tube."

Resident #2 was admitted to the facility on 10/11/15. Her cumulative diagnoses included status post placement of a gastrostomy tube (a surgical opening into the stomach whereby a feeding tube may be inserted).

A review of Resident #2's physician orders included the following medications, in part: 81 milligram (mg) chewable aspirin to be given as one tablet via tube every day.

On 10/4/16 at 9:07 AM, Nurse #5 was observed as she prepared medications for administration to Resident #2 via a gastrostomy tube. One of the medications pulled for administration was an 81 mg enteric coated (EC) aspirin. Nurse #5 was observed as she crushed the enteric coated aspirin, along with two other medications. Nurse #5 added approximately 20 ml of water to the combined crushed medications, flushed Resident #2 ' s gastrostomy tube with 40 ml of water using a syringe, and then administered the crushed medications mixed with water via the gastrostomy tube. After administering the medications, Nurse #5 flushed the gastrostomy tube with approximately 50 ml of water.

An interview was conducted on 10/4/16 at 2:11 PM with Nurse #5. Upon inquiry, the nurse reported she was not aware the order written for Resident #2's aspirin was for a chewable tablet instead of the enteric coated tablet used. The nurse stated she thought crushing an enteric coated aspirin would be okay since the medication would be administered via a

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F 332	Continued From page 39 gastrostomy tube. An interview was conducted on 10/5/16 at 11:00 AM with the facility's consultant pharmacist. During the interview, the medication administration to Resident #2 via gastrostomy tube was discussed. Upon inquiry, the pharmacist reported that an enteric coated aspirin should not be crushed. The consultant pharmacist stated that the nurse evidently gave the wrong medication when she crushed and administered an enteric coated aspirin tablet instead of a chewable aspirin tablet. An interview was conducted on 10/5/16 at 11:10 AM with the facility's Director of Nursing (DON). When asked what her thoughts were about the enteric coated aspirin being crushed and administered via a gastrostomy tube to Resident #2, the DON stated, "No, you would not crush that."	F 332		
F 353 SS=D	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. 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: Except when waived under paragraph (c) of this	F 353		11/3/16

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F 353	Continued From page 40 section, licensed nurses and other nursing personnel. 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. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to ensure adequate staff to provide activities of daily living care for 2 of 6 dependent residents(Resident #59 and #19) and apply splints for 1 of 1 sampled resident with contractures(Resident #1). The findings included: This tag is cross reference to: F312 1.Based on observations, resident and staff interviews and review of record, the facility failed to provide showers and shaving for 2 of 6 residents dependent upon staff for activities of daily living (ADL) assistance (Resident #59 and #19). This tag is cross referred to: F 318 2. Based on observations, interviews and record reviews, the facility failed to apply splints as ordered by the physician for 1 of 1 sampled residents with contracture (Resident #1). During an interview on 10/2/16 at 6:45PM, Nurse#5 indicated staffing had been an on-going issue with call outs. The charge nurse was	F 353	The bath/shower schedule and care plan for resident #59 was updated and the resident receives her bath/shower per schedule. The care plan and bath/shower schedule for Resident #19 was updated to insure the resident is offered a shave daily. The order for the splint for resident #1 was reviewed the splint applied as ordered by the aide. The care plan was reviewed to insure the application of the splint was in the care plan. The DON/designee will insure that the staffing pattern and assignments address completion of ADL tasks. Since all residents could be affected by the deficient practice, the DON/designee will review all resident's bath/shower schedule and ADL care as well as all residents with an order for a splint to insure that staffing patterns and assignments are sufficient to insure ADL care and application of splints were completed. The nursing staffing pattern will be reviewed by the DON/designee and administrator to insure that there is	

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F 353	Continued From page 41 expected to contact the Director of Nursing (DON) and attempt to find coverage, sometimes the DON could not be reached. On occasion you would get help from other hospital staff but they did not stay the whole shift. Nurse #5 reported when the replacement staff was not provided the extended care unit staff worked with whoever showed up for work. During an interview on 10/5/16 at 12:20 PM, the Director of Nursing (DON) stated that staffing was discussed daily with the hospital team in order to provide coverage for the extended care unit. The DON added there was no consistent way of ensuring coverage was available. The charge nurse could ask staff to stay an additional shift, call from the agency list and call other units within the hospital for assistance. The DON also indicated when all the resources were attempted and the hospital coverage was low, the extended care unit staff worked with the staff that were present. During an interview on 10/6/16 at 9:17 AM, Nurse #8 stated that staffing continued to be an on-going issue. When staff called in, there was not a replacement provided some of the care had not been done when there was only 1 or 2 NA ' s and 1 or 2 nurse ' s a shift. During an interview on 10/6/16 at 1:02 PM, the Administrator stated the DON was responsible for ensuring the extended care unit was fully covered. The DON and charge nurse was expected to implement the call out procedures and utilize staff from within the hospital, ask staff to work additional shifts and contact agency staff.	F 353	adequate staffing to meet the ADL care needs of the residents and the application of splints as ordered. The administrator will review the nursing schedule daily to insure the necessary number of nursing staff are available and scheduled to complete that ADL needs of the residents. The DON will monitor and report daily to the administrator the staffing levels for review and action as necessary. The DON will report to the quality assurance and Performance Improvement committee on a monthly basis compliance audits on bath/showers, grooming and application of splints as ordered as well as on staffing patterns for three months and quarterly thereafter for review and corrective action as necessary.	

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F 431	Continued From page 42	F 431		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		11/3/16

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F 431	Continued From page 43 Based on observations, record review and staff interviews, the facility failed to remove expired controlled substance medications from 1 of 2 medication carts (Hall Medication Cart for Rooms 239-259). The findings included: 1) An observation of the Hall Medication Cart (for Rooms 239-259) on 10/4/16 at 3:50 PM revealed 10 - 50 milligram (mg) tramadol tablets stored on the cart were past their expiration date of 7/31/16. The expired tramadol tablets were dispensed by the pharmacy on 10/27/15 and labeled for use by Resident #6. Tramadol is an opioid analgesic used to treat moderate to severe pain. It is a controlled substance medication. A review of Resident #6's October 2016 Physician Orders revealed there was a current order for 50 mg tramadol to be given as one tablet by mouth every 6 hours as needed for pain. An interview was conducted on 10/4/16 at 4:00 PM with Nurse #8. Upon review of the controlled substance medications, the nurse was asked if these expired medications should be stored on the medication cart. The nurse stated, "Absolutely not...I thought someone checked for this." An interview was conducted on 10/5/16 at 11:00 AM with the facility's consultant pharmacist. During the interview, the pharmacist stated she was aware expired controlled substance medications had been found on the med cart. When asked if the pharmacist would expect to find expired medications on a medication cart, she stated, "No."	F 431	The medication chart was checked by the DON for expired controlled substance medications for residents #6 and #18 to insure there were no expired medications. completion: 10/7/16 The nurse administering the expired medication was educated on the process for removing expired medications by the DON. completed: 10/7/16 All residents with controlled substance medications orders could be affected by the deficient practice. All medication carts were checked by the DON for expired controlled substances. Completed 10/21/16 Nursing staff were re-educated by the DON on the importance of checking for expired controls substances from the medication cart and removing the expired medications promptly. completion date: 11/3/16 The DON/designee will inspect the medication carts monthly for expired controlled substances. 11/3/16 The DON/designee will report the results on the inspections on a monthly basis for three months to the quality assurance and performance improvement committee and the pharmacy will report on bimonthly checks for expired medications quarterly thereafter for review and corrective action as necessary. Completion: 10/31/16	

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An interview was conducted on 10/5/16 at 11:10 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated she would not expect expired medications to be stored on the medication carts.

2) An observation of the Hall Medication Cart (for Rooms 239-259) on 10/4/16 at 3:50 PM revealed 5 - 0.25 milligram (mg) alprazolam tablets stored on the cart were past their expiration date of 8/31/16. The expired alprazolam tablets were dispensed by the pharmacy on 12/28/15 and labeled for use by Resident #18. Alprazolam is a benzodiazepine used to treat anxiety. It is a controlled substance medication.

A review of Resident #18's October 2016 Physician Orders revealed there was a current order for 0.25 mg alprazolam to be given as one tablet by mouth every day as needed for anxiety.

A review of Resident #18's Medication Administration Record (MAR) for September 2016 and October 2016 revealed the resident received one dose of alprazolam on 9/4/16 (after its expiration date of 8/31/16).

An interview was conducted on 10/4/16 at 4:00 PM with Nurse #8. Upon review of the controlled substance medications, the nurse was asked if these expired medications should be stored on the medication cart. The nurse stated, "Absolutely not...I thought someone checked for this."

An interview was conducted on 10/5/16 at 11:00 AM with the facility's consultant pharmacist. During the interview, the pharmacist stated she

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F 431	Continued From page 45 was aware expired controlled substance medications had been found on the med cart. When asked if the pharmacist would expect to find expired medications on a medication cart, she stated, "No." An interview was conducted on 10/5/16 at 11:10 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON stated she would not expect expired medications to be stored on the medication carts.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		11/3/16

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F 441	Continued From page 46 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility staff failed to don gloves and gowns when entering a room with Contact Precautions for one of two residents (Resident # 31) reviewed for Contact Isolation Precautions. The findings included: Resident #31 was admitted to the facility on 8/31/16. Review of her recent Minimum Data Set assessment dated 9/24/16 revealed Resident # 31 was severely cognitively impaired. The resident ' s diagnoses included right hip prosthesis infection, cellulitis (inflammation) of right lower limb and MRSA (Methicillin-resistant Staphylococcus Aureus, bacteria resistant to commonly used antibiotics). She required limited assistance with activities of daily living (ADL), was occasionally incontinent for bladder and was always incontinent for bowel. Review of Resident 31 ' s plan of care dated on 9/7/16 revealed the ADL self-care performance deficit, related to right hip cellulitis and MRSA from prosthesis. The goal was to improve current level of function in all ADL's. Some of the approaches were to provide treatment of	F 441	Nursing staff assigned to resident #31 will be educated on the infection control and contact precautions policy and procedure. All staff have the potential to be affected by the deficient practice so all staff assigned to the unit will be educated on infection control and contact precautions. The infection control policy was reviewed. All staff will be re-educated on infection control policies and procedures for residents on contact precautions. A sample of 10 observations per week of staff entering a room of a resident on contact isolation will be conducted by DON/designee. The results of these observations will be reported to the administrator weekly and to the quality assurance and performance improvement committee monthly for three months and quarterly thereafter for corrective action as necessary.	

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infection, assistance with ADLs and monitoring.
Record review of the Contact Precaution Policy, revised in May 2014, indicated that employees should don non-sterile gloves and gowns upon entering the room, remove them and perform hand hygiene with antiseptic agent before leaving the resident ' s environment.

Record review of the nurses ' notes, dated 9/16/16, revealed that Resident #31 received contact isolation precaution for MRSA to her right hip wound.

Record review revealed the physician ' s order dated 9/29/16 for Resident 31 ' s to obtain the stool test for infection.
Record review of the laboratory data revealed the result of Resident 31 ' s stool test collected on 9/29/16 as Clostridium Difficile (an intestinal infection, causes diarrhea).
Review of Resident 31 ' s Medication Administration Record (MAR) for September - October 2016 revealed that the resident received antibiotic treatment of MRSA and Clostridium Difficile infection and the right hip wound treatment.
On 10/2/06 at 5:00 PM, during the initial tour, Resident 31 ' s room was observed with the sign of contact precaution posted on the door. The gloves, gowns and masks were observed hung on the outside of the door. The door sign indicated: " Perform hand hygiene before entering room and wash hands with soap and water before leaving the room. Wear gloves when entering room or cubicle, and/or whenever touching the patient ' s intact skin, surfaces or articles in close proximity. Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items

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or potentially contaminated surfaces ... "

On 10/3/16 at 9:10 AM during an observation the door of Resident 31 ' s room was opened and Nurse Aide #2 was observed in the room. The sign of contact precaution was clearly visible on the door. She had gloves on her hands but did not wear the gown. The nurse aide came to the trash container near the resident ' s bed, replaced the plastic bag, sealed the trash inside the bag and put it into a bigger plastic trash container in the same room.

On 10/3/16 at 9:12 AM, during an interview, Nurse Aide #2 indicated that she was aware of the contact precaution sign and personal protective equipment (PPE) on the door of Resident 31 ' s room. She said that she usually put on gown and gloves when providing care. Nurse Aide #2 stated she entered the resident ' s room " to change the trash bags only " . She stated that she was not sure if she needed to use the gown.

On 10/3/16 at 12:50 PM, during an observation, Nurse Aide #1 came in to Resident 31 ' s room with gloves on her hands but she did not wear the gown. She took the meal tray with food left over from the resident ' s bed table and put it outside of the room in the meal cart.

On 10/3/16 at 12:53 PM during an interview, Nurse Aide #1 indicated that she was aware that Resident #31 was on contact precautions. The nurse aide explained that she did not put on a gown because she " just took the meal tray " from the resident.

On 10/6/16 at 12:50 PM, during an observation,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 Nurse Aide #3 came in to Resident 31 ' s room with the meal tray without wearing gloves or gown. The nurse aide used her ungloved hands to remove the resident ' s personal items from the bed table and then placed the meal tray on the bed table. On 10/6/16 at 12:53 PM during an interview Nurse Aide #3 indicated that she was aware that Resident # 31 was on isolation precautions and explained that she was going to wash her hands soon. The nurse aide added that she knew that donning gloves and handwashing was required but did not have time to put on gown and gloves before entering the room. On 10/5/16 at 2:00 PM during an interview Nurse #2 indicated that she was responsible for infection control program in the hospital ' s extended and acute care, including long term care facility. She confirmed that Resident #31 received contact precaution for MRSA and Clostridium Difficile. Nurse #2 reported that everybody needed to perform hand hygiene and put on gown and gloves prior to entering the room with contact precaution as well as remove the PPE in the room and wash hands before leaving the room. On 10/5/16 at 2:50 PM, during an interview, the Director of Nursing indicated that her expectation was for the staff to follow infection control policy and perform hand hygiene, put on gowns and gloves before entering the resident ' s room with contact precaution. The staff had to remove PPE in the resident ' s room and perform hand hygiene before leaving the room.	F 441		
F 520	483.75(o)(1) QAA	F 520		11/3/16

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F 520 SS=D	Continued From page 50 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in December 2015. This was for one recited deficiencies which were originally cited on November 2015 on a recertification survey and on the current recertification survey. The	F 520	Resident #1 was reviewed to insure that the splint was in place as ordered. All residents with splints were reviewed to insure the splints were in place as ordered and documented in the resident□s care plan. The role of the QAPI committee in	

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F 520	Continued From page 51 deficiency was in the areas of splint application. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F318: Splint application: Based on observations, staff interviews and record reviews, the facility failed to apply splints as ordered by the physician for 1 of 1 sampled residents with contracture (Resident #1). The facility was recited for F318 for failing to apply splints to residents with contractures during the November 6, 2015 recertification survey. On the current October 6, 2016 recertification survey the facility was cited again for not applying splints to a resident with contracture. During an interview on 10/6/16 at 4:37 PM, the Administrator stated that she was hired in February and was unaware of the previous deficiency. The Administrator indicated that she was aware of the quality assurance process and the corrective action required.	F 520	regards to insuring quality assurance and performance improvement was reviewed with the QAPI pmembers. completed 10/31/16. The plan of correction for the deficient practices will be reviewed with the QAPIcommittee. The audits measuring the compliance with splint application as per physician order will be presented monthly to the QAPI team by the DON. The administrator will insure that the team will monitor for effective correction action and implement corrective strategies if 100% compliance is not reached. The administrator/designee will be responsible to insure the QAPI committee continuously identifies and monitors the performance improvement process for all quality concerns and survey deficiencies. Compliance audits will be presented at each monthly meeting to determine the success of the corrective action in regards to splint application. Documentation will be placed in the minutes of the meeting to monitor the status of on-going concerns and the recommendations for continuing review and action.	