STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD FAYETTEVILLE, NC 28306

(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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, facility staff failed to follow the care plan to use 2 persons to provide mobility and incontinence care for 1 of 4 residents observed during bathing and incontinence care (Resident #10). The findings included: Resident #10 was admitted to the facility on 10/28/13 and had a diagnosis of multiple cerebrovascular accidents (CVAs), aphasia and dementia. The Annual Minimum Data Set (MDS) Assessment dated 10/9/16 revealed the resident ' s cognitive status could not be assessed and the resident required the total assistance of 2 persons for mobility and toileting and was incontinent. The Care Area Assessment dated 10/14/16 noted the resident was alert, nonverbal, did not make wants/needs known and required total care for all activities of daily living. Each resident in the facility had a Care Guide to tell the NAs (nursing assistants) how to care for the resident. The Care Guide for Resident #10 under Handling/Movement read: " Aid of 2 persons. " On 12/6/16 at 11:05 AM, NA #1 was observed to provide a bed bath and incontinence care for	F 282	F282 NA #1 is no longer employed at the facility. Resident #10 will continue to receive a 2 person assist for mobility and toileting per the Resident Care guide. 100% return demonstration of all licensed nurses and nursing assistants was completed by the Staff Facilitator beginning on 12/07/2016 to assure the Licensed Nurse and\or Nursing Assistants were performing mobility and toileting to include required number of persons per the Resident Care guide and to be completed on 1/04/2017. Re-training was immediately conducted with licensed nurse and\or nursing assistant during audit for any identified areas of concerns by Quality improvement nurse and Staff facilitator. 100% in-service was initiated by the Staff Facilitator on 12/07/2016 of licensed nurses and nursing assistants in regards to the Safe Movement and Handling Policy to include reading the resident care guide prior to all mobility and toileting to be completed by 1/04/2017. All newly hired licensed nurses and nursing	1/4/17

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

Electronically Signed | 12/23/2016

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F 282	Continued From page 1 Resident #10. The NA was observed to provide the care by herself struggling to turn the resident over to provide care. NA #1 stated in an interview on 12/7/16 at 8:10 AM that Resident #10 was a 2 person assist for care. When asked why she provided the care by herself the NA stated: " Because it took longer to go get someone who was willing to help than to do it herself. " On 12/7/16 at 5:10 PM the Administrator stated she would re-educate the NA because she did not want to have an accident happen with the resident during care.	F 282	assistants will be in-serviced of the Safe Movement and handling policy to include reading the resident care guide prior to all mobility and toileting. Observations of resident care to include mobility and toileting to be completed on 10% of licensed nurses and nursing assistants to include resident # 10 and residents that require 2 person assist by Quality Improvement nurse and Staff facilitator to ensure the care guide is followed for the required number of persons utilizing a Resident Care audit tool 3 times a week for 4 weeks, then weekly for 8 weeks. All licensed nurses and\or nursing assistants will be immediately retrained for any identified areas of concern by Quality improvement Nurse and Staff facilitator during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 12 weeks to ensure all areas of concerns have been addressed. The Executive QI Committee will meet monthly and review the Resident Care Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		1/4/17

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F 312	Continued From page 2 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide personal care for 1 of 4 residents observed to receive incontinence care (Resident #10). The findings included: Resident #10 was admitted to the facility on 10/28/13 and had a diagnosis of multiple cerebrovascular accidents (CVAs), aphasia and dementia. The resident ' s Care Plan initiated 11/13/13 noted the resident was unable to express emotion and share information characterized by lack of speech related to aphasia secondary to CVA. The Care Plan noted the resident was at risk for skin breakdown related to incontinence and impaired mobility. The intervention was to monitor for incontinence routinely and give care as needed. The Annual Minimum Data Set (MDS) Assessment dated 10/9/16 revealed the resident ' s cognitive status could not be assessed and was total care for all activities of daily living. The MDS revealed the resident was incontinent. The Care Area Assessment (CAA) dated 10/14/16 for Activities of Daily Living (ADLs) noted the resident required total care for all ADLs. The CAA noted the resident was alert, nonverbal and did not make wants/needs known. On 12/6/16 at 11:05 AM, NA (nursing assistant) #1 was observed to provide a bed bath and incontinence care for Resident #10. The NA was observed to release the incontinent brief. There appeared to be 2 briefs on the resident and both were saturated with urine. The NA stated the night shift put a liner in the resident ' s incontinent brief because the resident was a heavy wetter.	F 312	F312 NA #1 no longer works at facility. Resident # 10 will continue to receive timely incontinent care per policy. 100% audit of all residents was initiated on 12/6/16 by Staff Facilitator to include resident #10 to assure timely personal care to include incontinent care to be completed on 1/4/2017. Personal care will immediately be provided for the resident and re-training to the nursing assistant for any areas of concern to be addressed by quality improvement nurse/staff facilitator/DON during audit. 100% of licensed nurses and nursing assistants were re-educated on providing timely personal care for the resident to include incontinent care and reporting to hall nurse if care cannot be provided timely by staff facilitator on 12/6/16 to be completed on 1/4/17. All newly hired nursing assistants will be in-serviced by the Staff Facilitator during orientation on providing timely personal care for the resident to include incontinent care and reporting to hall nurse if care cannot be provided timely. Resident care audit tools will be completed by quality improvement nurse/Staff facilitator on 10% of residents to include resident # 10 to ensure residents received personal care to include timely incontinent care 3 X a week for 4 weeks and weekly X 8 weeks. All nursing assistants will be immediately	

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F 312	Continued From page 3 While providing the care the NA stated she had not checked the resident for incontinence since she began her shift at 7:00 AM. The NA stated she had been bathing other residents and had just gotten to this resident. The NA was observed to use the incontinent pad to turn the resident over on his side and the incontinent pad was observed to be saturated with urine. There was no redness or skin breakdown noted on the resident ' s bottom. During the care, the NA stated she never asked for help for something she could do herself. An interview was conducted with the Director of Nursing (DON) on 12/6/16 at 4:02 PM. The DON stated brief liners were used for residents that were heavy wetters but the NAs were supposed to check incontinent residents every 2 hours and if unable to do this could let the other NA on the hall know she needed help.	F 312	retrained for any identified areas of concern by staff facilitator/quality improvement nurse during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 12 weeks for completion and to ensure all areas of concerns have been addressed. The Executive QI Committee will meet monthly and review the Resident Care Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 322 SS=E	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services	F 322		1/4/17

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F 322	Continued From page 4 to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to administer medications separately via gastric tube and flush between each medication for 1 of 4 residents observed to receive medications per gastric tube (Resident #10). The facility also failed to follow physician ' s orders for water flushes via gastric tubes for 3 of 4 residents observed to receive medications by gastric tube (Resident #4, Resident #9 and Resident #11). The findings included: Resident #10 was admitted to the facility on 10/28/13 and had a diagnosis of multiple cerebrovascular accidents (CVAs), aphasia (lack of speech, dysphagia (difficulty swallowing) and PEG (percutaneous endoscopic gastric) tube. Review of the December 2016 monthly physician ' s orders revealed Resident #10 received his oral medications via PEG (feeding) tube. There was an order to give each medication separately and flush with 15mls (milliliters) of water after each medication. On 12/6/16 at 12:05 PM, Nurse #1 was observed to prepare and administer medications to Resident #10. The Nurse was observed to dispense the following medications into a paper medication cup: Certavite Vitamin 1 tablet, Vitamin C 500mg (milligram) 1 tab, Folic Acid 1mg Spironolactone 25mg 1 tab, Hydralazine 100mg 1 tab, Vitamin B12 1,000mcg (micrograms) 1 tablet, Clonidine 0.1mg 1 tablet and Norvasc 10mg 1 tablet. The nurse then	F 322	F322 Nurse # 1 no longer works at facility. Resident #10 received medications separately via gastrostomy tube per physician order on 12/8/16 by hall nurse with supervision by Staff facilitator. Resident # 4, #9 and # 11 gastrostomy tubes were flushed per physician□s order on 12/8/16 by hall nurse with supervision by the Staff facilitator. 100% of license nurse were observed administering medications via gastrostomy\J tube to ensure physician orders are being followed to include orders for gastrostomy fluids and administering medications separately initiated on 12/6/16 by staff facilitator/quality improvement nurse to be completed by 1/4/17. The staff facilitator/quality improvement nurse/DON immediately retrained the license nurse for any identified areas of concern during the audit. 100% of license nurses will be in-serviced by Staff facilitator regarding the 6 rights of medication administration to include following physician orders for gastrostomy fluids and administering G tube\J tube medications separately by 1/4/2017. All newly hired license nurses will be	

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F 322	Continued From page 5 placed the paper cup in the pill crusher and crushed all the medications together. The nurse was observed to add water to the crushed pills and stir the mixture. The nurse was then observed to flush the gastric tube with water and pour the pill mixture into the catheter tip syringe and flush the mixture with water. At the completion of the medication pass the order on the Medication Administration Record to give each medication separately and flush with 15 mls water after each medication was reviewed with the nurse. The Nurse stated she saw the order and asked one of the nurses about it and the nurse told her to just give the medications all together. On 12/6/16 at 4:15 PM the Interim Director of Nursing stated in an interview that each medication should be given individually and flushed after each medication. 2. Resident #4 was admitted to the facility on 9/2/16 and re-admitted on 12/6/16 and had diagnoses of cerebrovascular accident with right hemiplegia (stroke with right side paralysis), dysphagia (difficulty swallowing), percutaneous endoscopic jejunostomy Tube (J-tube) and severe gastroparesis (delayed emptying of the stomach). The Care Plan for Resident #4 dated 10/17/16 noted a gastric tube was required to assist the resident to maintain or improve the nutritional status characterized by weight loss and to administer tube feeding formula and water flushes as ordered by the physician. The Annual Minimum Data Set (MDS) Assessment dated 10/21/16 revealed the resident had short and long term memory loss and severe cognitive impairment. The MDS revealed the resident required total care for feeding and received nutrition and fluids via gastric tube.	F 322	in-serviced by the Staff Facilitator during orientation regarding the six rights of medication administration to include following physician orders for gastrostomy fluids and administering G tube\J tube medications separately. The Medication Pass Audit Tool will be utilized by quality improvement nurse/ Staff facilitator/DON with observation of 10% of license nurses to ensure license nurses are following physician orders during medication administration to include gastrostomy medications being separated when administering and gastrostomy fluids administration weekly x eight weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by staff facilitator/quality improvement nurse/DON. The DON will review and initial the Medication Pass Audit Tool for appropriate medication administration to residents to include resident #10,#4, #9 and #11 for completion, and to ensure all areas of concern were addressed weekly x eight weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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The Care Area Assessment (CAA) for Feeding Tube dated 10/20/16 revealed the resident had a feeding tube in place. The CAA revealed the resident was unable to swallow or eat food and was at risk for aspiration.

On 12/7/16 at 8:00 AM, Resident #4 was observed lying in bed on his right side with a towel containing emesis beside his head. Nurse #1 was observed to administer medication for pain and NA (nursing assistant) #1 asked Nurse #1 to give the resident medication for nausea and vomiting as the resident had just vomited.

Review of the physician ' s admission orders dated 12/6/16 revealed an order to administer 30mls (milliliters) water flush via J-Tube before medications. The order further instructed to give each medication separately via J-tube, to flush with 15mls of water after each medication, and flush the J-tube with 30mls of water after all medications were given.

On 12/7/16 at 12:10 PM, Nurse #1 was observed to administer medications to Resident #4. The Nurse was observed to prepare 5 medications, crushing tablets and mixing each with water in a separate cup. The Nurse was observed to flush the J-tube with 30mls of water and poured the first medication into the J-tube and flushed with 30mls of water. The nurse was observed administer the other 4 medications and flushed the J-Tube with 30mls of water after each of the medications. The nurse then stated she would flush the J-tube with 80ccs water flush ordered to be given at 12 Noon.

On 12/7/16 at 12:22 PM the order for 15mls water between medications on the Medication Administration Record was reviewed with Nurse #1. The Nurse stated she was aware of the order but they had had so much trouble with the resident ' s J-tube clogging up that she flushed

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with 30mls of water between medications.
On 12/7/16 at 2:05 PM the resident ' s Physician stated in an interview that Resident #4 had significant gastroparesis for which he was on a lot of medications. The Physician explained they were unable to increase the amount of the resident ' s tube feedings because he would throw it up and the resident had a history of aspiration pneumonia. The Physician added he would not want to give the resident extra fluids by J-tube because he would throw it up.
3. Resident #9 was admitted to the facility on 6/7/13 and had diagnoses of adult failure to thrive, cerebrovascular accident (CVA), dysphagia (difficulty swallowing), congestive heart failure and chronic kidney disease, Stage III.
The Care Plan dated 3/3/16 noted that tube feeding was required to assist the resident in maintaining or improving nutritional status. The Care Plan directed staff to provide tube feeding formula and water flushes as ordered by MD.
The Care Area Assessment (CAA) for Cognitive Loss dated 3/19/16 revealed the resident was alert and confused and unable to make her needs known. The CAA revealed the resident was able to answer direct yes and no questions and received medications, nutrition and hydration via feeding tube.
The most recent Minimum Data Set (MDS) Assessment dated 9/10/16 revealed the resident had severe cognitive impairment, non-ambulatory, was totally dependent on staff for eating, and was fed by a feeding tube.
Review of the December 2016 monthly physician ' s orders for Resident #9 read: " Flush GT (gastric tube) with 30ml (milliliters) water before and after meds (medications). "
On 12/6/16 at 9:58 AM, Nurse #1 was observed to administer medications to Resident #9. The

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nurse was observed to flush the gastric tube with 30mls of water and administer a medication via gastric tube. The nurse then flushed the gastric tube with 60mls of water. While flushing the tube, the Nurse stated she was supposed to flush with 30mls of water but she liked to use more water because she had a problem with g-tubes clogging up.

On 12/6/16 at 10:50 AM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated when administering medications and flushes by gastric tubes, the order is on the Medication Administration Record (MAR) right in front of you and if it says flush with 30mls, the nurse should flush with 30mls and not 60mls.

On 12/6/16 at 4:20 PM the Director of Nursing stated in an interview that she expected the nurses to follow the MAR.

4. Resident #11 was admitted to the facility on 11/14/16 and had diagnoses of anoxic brain damage, aphasia (loss of ability to talk and understand speech), dysphagia (difficulty swallowing) and gastric tube.

The Admission Minimum Data Set (MDS) Assessment dated 11/21/16 revealed the resident had short and long term memory loss and severe cognitive impairment. The MDS revealed the resident required total care and was fed by gastric tube.

The Care Area Assessment (CAA) for Cognitive Loss and Nutrition dated 11/23/16 revealed the resident was non-verbal and was unable to make her needs known in writing and/or with gestures. The CAA noted the resident received nothing by mouth and received all hydration and nutrition by gastric tube. The CAA for Feeding Tube dated 11/23/16 noted the resident was at risk for aspiration and would receive formula and water

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F 322	Continued From page 9 flushes as ordered. The resident ' s Care Plan dated 11/14/16 noted the resident required tube feeding to assist the resident in maintaining or improving nutritional status related to aspiration, chewing problem, dysphagia, failure to eat, inadequate oral intake and swallowing impairment. The Care Plan noted the resident was NPO (nothing by mouth) and to administer tube feeding formula and water flushes as ordered by the physician. Review of the monthly physician orders for December 2016 revealed an order to flush the resident ' s gastric tube with 250mls (milliliters) of water every 6 hours. Nurse #2 was observed during a medication pass for Resident #11 on 12/6/16 at 9:20 AM. The nurse was observed to administer the resident ' s medications and started to administer 250mls water flush to the resident. The nurse was asked to recheck the time of the order prior to administering the water flush. The Nurse was observed to review the Medication Administration Record (MAR) and stated the water flush was not due until 12 Noon. The Nurse stated the flushes were usually ordered once a shift and she did not notice the flushes were timed. On 12/6/16 at 4:20 PM the Director of Nursing stated in an interview she expected the nurses to follow the orders on the MAR.	F 322		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323		1/4/17

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F 323	Continued From page 10 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to use 2 persons to provide care for a resident, putting the resident at risk for injury for 1 of 4 residents observed to receive personal care (Resident #10). The findings included: Resident #10 was admitted to the facility on 10/28/13 and had a diagnosis of multiple cerebrovascular accidents (CVAs), aphasia and dementia. The Annual Minimum Data Set (MDS) Assessment dated 10/9/16 revealed the resident ' s mental status could not be assessed, was non-ambulatory and required total assistance of 2 persons for bed mobility and toileting. The resident ' s weight was 245 pounds. The Care Area Assessment dated 10/14/16 noted the resident was alert, nonverbal, did not make	F 323	F 323 NA #1 is no longer employed at the facility. Resident #10 will continue to receive a 2 person assist for mobility and toileting per the Resident Care guide. 100% return demonstration of all licensed nurses and nursing assistants was completed by the Staff facilitator/quality improvement nurse/DON beginning on 12/6/2016 to assure the Licensed Nurse and\or Nursing Assistants were performing mobility and toileting to include required number of persons per the Resident Care guide and to be completed on 1/4/2016. Re-training was immediately conducted with licensed nurse and\or nursing assistant during audit for any identified areas of concerns by Staff	

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	345376	A. BUILDING _____ B. WING _____	C 12/07/2016

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F 323	Continued From page 11 needs known and was total care for all activities of daily living. Each resident in the facility had a Care Guide to tell the NAs (nursing assistants) how to care for the resident. The Care Guide for Resident #10 under Handling/Movement read: " Aid of 2 persons. " On 12/6/16 at 11:05 AM, NA (nursing assistant) #1 was observed to provide a bed bath and incontinence care for Resident #10. The NA was observed to raise the bed to a high position from the floor. The NA was observed to provide the care by herself. During the bath the resident was observed lying flat on his back and the NA used the draw sheet to roll the resident over on the left side and pushed the resident over further to pull the corner of the incontinent brief from under the resident. The resident was noted to be a large person and the NA was observed to struggle to hold the resident over with one hand while using the other hand to pull the corner of the brief from under the resident. An interview was conducted with MDS Nurse #1 on 12/7/16 at 7:45 AM. The MDS Nurse stated the resident was total care and required 2 person assistance for personal care. The MDS Nurse stated the resident was very large and needed someone to hold the resident over while the other person provided the care. NA #1 stated in an interview on 12/7/16 at 8:10 AM that Resident #10 was a 2 person assist for care. When asked why she provided the care by herself the NA stated: " Because it took longer to go get someone who was willing to help than to do it herself. " On 12/7/16 at 5:10 PM the Administrator stated she would re-educate the NA because she did not want to have an accident happen with the resident during care.	F 323	facilitator/DON/Quality improvement nurse. 100% in-service was initiated by the Staff Facilitator on 12/6/16 of licensed nurses and nursing assistants in regards to the Safe Movement and Handling Policy to include reading the resident care guide prior to all mobility and toileting to be completed by 1/4/2016. All newly hired licensed nurses and nursing assistants will be in-serviced by the Staff Facilitator during orientation on the Safe Movement and handling policy to include reading the resident care guide prior to all mobility and toileting. Observations of resident care to include mobility and toileting to be completed on 10% of licensed nurses and nursing assistants to include resident # 10 and residents that require 2 person assist by quality improvement nurse/staff facilitator/DON to ensure the care guide is followed for the required number of persons to prevent putting the resident at risk for injury utilizing a Resident Care audit tool 3 times a week for 4 weeks, then weekly for 8 weeks. All licensed nurses and\or nursing assistants will be immediately retrained for any identified areas of concern by quality improvement nurse/staff facilitator/DON during the observation. The Director of Nursing will initial and review the results of the resident care audit tool weekly X 12 weeks for completion and to ensure all areas of concerns have been addressed. The Executive QI Committee will meet	

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F 323	Continued From page 12	F 323	monthly and review the Resident Care Audit tool and address any issues, concerns and\or trends and to make changes as needed, to include the continued frequency of monitoring x 3 months.	
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to give medication as the physician ordered for 1 (Resident # 1) of 3 residents reviewed for unnecessary medications leading to 15 additional doses of a diuretic. The findings include: Resident #1 was admitted to the facility on	F 329	F329 A physician clarification order was obtained for resident #10 diuretic by Staff facilitator on 12/6/2016. 100% audit of all residents MAR's to include resident #10 was compared to	1/4/17

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F 329	Continued From page 13 10/03/2016, with diagnosis to include Chronic Anemia, Dysphagia, Kidney Disease, Hypertension, Peripheral Vascular Disease, Renal Insufficiency, Non-Alzheimer ' s Dementia, Parkinson ' s disease, and Psychotic Disorder. His comprehensive minimum data set (MDS) assessment dated 06/24/2016 revealed severe cognitive impairment. A physician order dated 10/03/2016, was for Zaroxolyn, a diuretic medication used to treat high blood pressure and fluid accumulation, 2.5 milligrams (mg) by mouth on Monday, Wednesday, and Friday. A review of Residents #1 ' s Medication Administration Record (MAR), revealed the resident received Zaroxolyn 2.5 mg on 15 additional days on November 1-Tuesday, November 3-Thursday, November 5-Saturday, November 6-Sunday, November 8-Tuesday, November10-Thursday, November 12-Saturday, November 13-Sunday, November15-Tuesday, November17-Thursday, November 22-Tuesday, November 24-Thursday, November 29-Tuesday, December 3-Saturday, and December 4-Sunday, 2016. An observation of Resident #1 was conducted on 12/04/2016, the Resident was seated in his wheelchair in his room eating his dinner and watching his television. His hair was combed, and his clothes were clean. He was alert, calm, and responded to his name when called. An interview on 12/07/2016 at 11:00 am with the Director of Nursing, she stated she was not aware of the incorrect data until 12/06/2016. She explained usually the nurses mark through the days the resident does not receive the medication, but there was no markings done for the month of November or December on the Medication Administration Record. She stated it	F 329	current physician orders to ensure medications are being administered per physician orders and medications with specific days are marked accordingly will be conducted by Quality Improvement nurse/staff facilitator and completed on 1/4/16. A clarification order will be obtained from MD for all identified areas of concerns during the audit by Quality improvement nurse/staff facilitator. 100% of all licensed nurses will be in-serviced by Staff Facilitator regarding 6 rights of medication administration to include reading the MAR to accurately administer the medication per the physicians order and blocking of the MAR for medications that are required to be given specific days of the week by 1/4/2016. All newly hired license nurses will be in-serviced by the Staff Facilitator during orientation regarding 6 rights of medication administration to include reading the MAR to accurately administer the medication per the physicians order and blocking of the MAR for medications that are required to be given specific days of the week . The Quality Improvement nurses/staff facilitator will monitor 10% of residents to include resident #1 MAR to ensure that medications are being administered per physician order and blocking of medications that are to be administered specific days of the week utilizing a MAR Audit tool weekly x eight weeks then monthly x 1 month. A clarification order will be obtained from the MD for all area of concerns and licensed nurse to be re-trained during audit by DON/Quality	

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F 329	Continued From page 14 was her expectation that the floor nurse would have carried out the order as prescribed and that marking off those days did not excuse the medication being given. The resident ' s MAR was updated on 12/06/2016 to mark off the days that the medication is not to be given. On 12/7/2016 at 1:15 pm Nurse #1 was interviewed. She indicated her initials on the MAR would indicate she had administered Zaroxolyn to the Resident. An interview on 12/07/2016 at 1:55 pm with the physician regarding the additional doses of Zaroxolyn, he explained the Zaroxolyn was ordered to supplement the primary diuretic (Lasix). He explained he thought it would be minimal or no harm and he actually thought it may have helped take some of the fluid retention from the Resident. He also revealed he had a conversation with the staff after being informed of the incident regarding the frequency of the dose for Resident #1. On 12/7/2016 at 2:25 pm Nurse #2 was interviewed. She indicated her initials on the MAR would indicate she had administered Zaroxolyn to the Resident. An interview on 12/07/2016 at 4:00 pm, with the facility ' s consultant pharmacist revealed she did her audit on prior months data and had not reviewed November and December 2016 Medication Administration Record. She responded it would be minimal to no harm to the resident because the extra diuretic was to support the Lasix (another diuretic) the Resident was already receiving. On 12/07/2016 at 4:55 pm, the Administrator was interviewed. She stated she was aware of the medication error on Resident #1. She found it on 12/06/2016 and had informed the DON and they had started a plan of correction to re-educate the	F 329	improvement nurse/staff facilitator. The DON will review and initial the MAR audit tool weekly X 12 weeks for completion and to assure that all areas of concerns have been addressed. The Executive QI committee will meet monthly and review the MAR Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 329	Continued From page 15 nursing staff. The physician had been notified of the error. She acknowledged the nursing staff had misread the order and the staff would be in-serviced and counseled accordingly.	F 329		
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to be free of a medication error rate greater than 5 percent as evidenced by 9 errors out of 34 opportunities resulting in a medication error rate of 26.4 percent for 2 of 5 residents observed during medication pass (Resident #10 and Resident #4). The findings included: 1a. Resident #10 was admitted to the facility on 10/28/13 and had a diagnosis of hypertension, multiple cerebrovascular accidents (CVAs), aphasia (lack of speech, dysphagia (difficulty swallowing), PEG (percutaneous endoscopic gastric) tube and glaucoma. Review of the December 2016 monthly physician ' s orders revealed the resident received all oral medications via PEG (feeding) tube. There was an order to give each medication separately and flush with 15mls (milliliters) of water after each medication. On 12/6/16 at 12:05 PM, Nurse #1 was observed to administer medications to Resident #10. The nurse was observed to place the following medications in a paper medication cup: Certavite	F 332	F 332 Nurse # 1 no longer works at facility. Resident #10 received medications separately via gastrostomy tube per physician order on 12/8/16 by hall nurse with supervision by staff facilitator. Resident # 10 and #4 received medications per gastrostomy tube timely per physician order on 12/8/16 by hall nurse with supervision by staff facilitator. 100% of license nurse were observed administering medications to include via gastrostomy\ J tube to ensure medication error rate is less than 5%, physician orders are being followed to include orders for gastrostomy fluids and administering medications separately and medications administered timely initiated on 12/6/16 by Staff facilitator to be completed by 1/4/2017. The Staff facilitator/DON/quality improvement nurse immediately retrained the license nurse for any identified areas of concern during	1/4/17

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F 332	Continued From page 16 Vitamin and Mineral Supplement 1 tablet, Vitamin C 500mg 1 tablet, Folic Acid 1mg 1 tablet, Spironolactone 25mg 1 tablet, Hydralazine 100mg 1 tab, Vitamin B12 1,000 micrograms 1 tablet, Clonidine 0.1mg 1 tablet and Norvasc 10mg 1 tablet. The nurse was then observed to place the paper medication cup in the pill crusher and crushed all the pills together. The nurse was observed to pour the powdered meds in a cup and add water and stir the medications together. The nurse was observed to flush the PEG tube with water and then poured the medication mixture into the tube and then flushed with the remainder of the water flush. At the completion of the medication pass the order on the Medication Administration Record (MAR) to give each medication separately and flush with 15mls of water after each medication was reviewed with Nurse #1. The Nurse stated she saw the order and asked one of the nurses about it and was told to just give all the medications together. On 12/6/16 at 4:15 PM the Director of Nursing (DON) stated in an interview that each medication should be given individually and flushed after each medication. The DON further stated the order was right there on the MAR. 1b. Review of the December 2016 monthly physician ' s orders revealed orders for the following medications: Sprionolactone 25mg (milligrams) twice a day at 10:00 AM and 4:00 PM, Alphagan P Solution 0.1% (percent) 1 drop in each eye twice a day at 10:00 AM and 4:00 PM, Clonidine 0.1mg three times a day at 10:00 AM, 4:00 PM and 12:00 Midnight, Apresoline 100mg three times a day scheduled at 8:00 AM, 4:00 PM and 12:00 Midnight. Nurse #1 was observed to administer the above medications to Resident #10 at 12:05 PM. At the completion of the medication pass the Nurse	F 332	the audit. 100% of license nurses will be in-serviced by Staff facilitator regarding the 6 rights of medication administration to include following physician orders for gastrostomy fluids and administering G tube\J tube medications separately and time frame for medication administration, notifying of DON and MD if medication can not be administered timely by 1/4/17. All newly hired license nurses will be in-serviced by the Staff Facilitator during orientation regarding the six rights of medication administration to include following physician orders for gastrostomy fluids and administering G tube\J tube medications separately and time frame for medication administration,notifying of DON and MD if medication can not be administered timely. The Medication Pass Audit Tool will be utilized by Staff facilitator/quality improvement nurse/DON with observation of 10% of license nurses to ensure medication error rate less than 5%, license nurses are following physician orders during medication administration to include gastrostomy medications being separated and medications are administered within the required time frame when administering and gastrostomy fluids administration weekly x eight weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by Staff facilitator/quality	

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F 332	Continued From page 17 stated she was the only nurse on the hall and sometimes had to give medications for 9 residents on another hall as well. On 12/6/16 at 4:08 PM the Director of Nursing (DON) stated in an interview that Nurse #1 had not expressed a concern to her that she could not get her medications done before 2:30 PM. 2. Resident #4 was admitted to the facility on 9/2/16 and re-admitted on 12/6/16. The resident had diagnoses that included cerebrovascular accident (CVA), chronic peptic ulcer and gastric esophageal reflux disease (GERD). On 12/6/16 at 4:08 PM the Director of Nursing stated Nurse #1 had not expressed a concern to her that she could not get her meds done before 2:30 PM. The December 2016 monthly physician ' s orders for Resident #4 revealed orders for the following medications: Prevacid solutab 30mg (milligrams) twice a day at 8:00 AM and 8:00 PM, Eryped 200mg per 5ml (milliliters) suspension. Give 6.25mls at 8:00 AM, 2:00 PM and 8:00 PM, Amoxicillin-Potassium Clavulanate 875mg/125mg 1 tablet every 12 hours at 8:00 AM and 8:00 PM and Sucralfate 1 gram per 10ml suspension, give 10ml at 6:00 AM, 11:30 AM, 4:30 PM and 8:00 PM. Nurse #1 was observed during a medication pass to administer the resident ' s 8:00 AM medications to Resident #4 on 12/7/16 at 12:10 PM.	F 332	improvement nurse/DON. The DON will review and initial the Medication Pass Audit Tool for completion and appropriate medication administration to residents to include resident #10 and #4 for completion, and to ensure all areas of concern were addressed weekly x eight weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 353		1/4/17

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F 353	Continued From page 18 provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to	F 353		

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F 353	Continued From page 19 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family, and staff interviews, the facility failed to provide adequate staffing to perform incontinence care as needed for 1 of 4 residents (Resident #10), failed to maintain a medication error rate less than 5 percent for 2 of 5 residents observed during medication pass (Resident #10 and Resident #4), and failed to provide the services of a registered nurse (RN) for 8 consecutive hours per day on 2 dates, 12/01/2016 and 12/02/2016. Additional residents ' interviews (Resident #5 and Resident #8) and family interviews (Resident #1 and Resident #7) revealed additional concerns regarding staffing. The findings included: This tag is cross-referenced to: 1. F 312. Based on observation, record review and staff interviews the facility failed to provide incontinence care for 1 of 4 residents observed to receive incontinence care (Resident #10). 2. F 332. Based on observation, record review and staff interviews the facility failed to be free of a medication error rate greater than 5 percent as evidenced by 3 errors out of 34 opportunities resulting in a medication error rate of 8.8 percent for 2 of 5 residents observed during medication pass (Resident #10 and Resident #4). 3. F 354. Based on record review and staff interviews, the facility failed to provide the services of a registered (RN) for 8 consecutive hours per day on 2 dates, 12/01/2016 and 12/02/2016. On entry to the facility 12/04/2016 at 4:00 pm, noted Daily Staffing Posted for day shift (7:00 am	F 353	F 353 Sufficient Staff Residents #10 and #4 received medications separately and on time via gastrostomy tube per physician order on 12/8/16 by hall nurse with supervision by Staff facilitator. Resident #10 received timely incontinent care on 12/8/16 by certified nurse assistant supervised by Staff facilitator. On 12/7/16 the Administrator and the Director of Nursing reviewed the staffing schedule to ensure sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. On 12/7/16 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Director of Nursing was replace on 12/15/2016. The new Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents. The Case Mix Index will be reviewed weekly to assure the acuity of the resident is taken in to account with the clinical staffing patters to meet the needs of the residents. On 12/8/16 the Corporate Consultant in-serviced the Administrator and Director of Nursing regarding Sufficient Staff. The	

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F 353	Continued From page 20 - 3:00 pm) was for 4 Nursing Assistants for the entire facility with a census of 108. An interview with Nursing Assistant #2 on 12/04/2016 at 6:15 pm, revealed she was the only Nursing Assistant assigned to the locked unit for day shift. She explained it is difficult to maintain care for the 20 residents in the locked unit alone. She expressed it is easier to watch and monitor the residents if there are 2 nurse assistants in the locked unit. During an interview on 12/04/2016 at 6:30 pm with the Nurse #3, she verified the posted staffing was correct. An interview on 12/04/2016 at 6:35 pm with Resident #8 revealed there was not enough staff to get him up early and go to the dining room because some people did not come to work. He expressed he was told by the nursing staff he could not go in the dining room until enough staff came in to monitor the residents in the dining hall, so he had to remain in his room until the additional staff arrived. He explained it has been occurring recently and is not improving. An interview on 12/04/2016 at 6:45 pm with Resident #6 revealed she thought the facility was short staffed on most weekends. She explained she would be placed on the toilet and then it would take ten minutes to an hour for the staff to come back sometimes. She stated she could ring for help, but it took a while for help to come. An interview on 12/04/2016 at 6:59 pm with Resident #7 ' s Family Member revealed concerns regarding having to wait long periods of time (over 30 minutes) for toileting assistance. She revealed she had been on the unit most of the afternoon and evening and there would only be one Nursing Assistant for all the residents in the locked unit. She revealed she had come in sometimes just to make sure Resident #7 got fed	F 353	Sufficient Staff in-service included the following: A. 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. B. The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. On 12/7/16 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Director of Nursing was replace on 12/15/2016. The new Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents. The Case Mix Index will be reviewed weekly to assure the acuity of the resident is taken in to account with the clinical staffing patters to meet the needs of the residents. The facility has hired a new RN-Director of Nursing on 12/15/2016, 5 registered nurses, 5 LPNs and 10 Certified Nursing Assistants to fill the vacant position in the current schedule. The open position that remain are 2 full time licensed nurse positions for every other weekend. These positions will be filled by 1/4/16. On 12/8/16, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to meet the needs of the residents based upon the acuity level	

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	345376	A. BUILDING _____ B. WING _____	C 12/07/2016

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F 353	Continued From page 21 before his food got cold because there is " not enough help " . She stated, " Twenty or more people is too much for one Nurse Assistant. " An interview with the Scheduler on 12/05/2016 at 3:10 pm revealed her normal staffing pattern was 8 or 9 Nurse Assistants on day shift, 7 or 8 Nurse Assistant on evening shift, and 6 nurse assistants on night shift. She explained when staff called out the Director of Nursing usually would call her to see if they could get some replacements. She revealed it was hard to replace call outs especially on the weekends and it is hard also because there were no agency nurses. An interview 12/05/2016 at 3:40 pm with the Acting Director of Nursing she revealed she was aware there were only 4 nurse assistants on 12/04/2016 day shift for a census of 108. She explained the Scheduler tried to maintain two nurse assistants per hallway but cannot always. On 12/06/16 at 09:55 am, a phone interview with Resident #1 Family Member revealed concerns about Resident #1 eating his food and waiting to be toileted. The Family Member revealed sometimes the Resident required patience and he does not want to leave his room. He frequently required cueing to consume his food. There is sometimes " not enough staff " she explained. She stated, " they (the facility) leave one person back there with all the people (the residents in the locked unit). " During an interview on 12/06/2016 5:40 pm with the Administrator, she revealed the facility is trying to recruit nurses for the facility. She stated it is her expectation the facility maintains adequate staff to provide excellent patient care and maintain patient safety at all times.	F 353	as identified by the Case Mix Index score. The QI monitoring tool will assist with the facility assuring the residents reach their highest practicable physical, mental and psychosocial well-being. The Administrator and the Director of Nursing will utilize the Sufficient Staff tool daily, at the beginning of each shift to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately with assuring the proper staff are on duty or the utilization of administrative nurses are pulled to the hall. The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patters are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report. The administrator will present findings at the monthly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 354 SS=D	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	F 354		1/4/17

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F 354	Continued From page 22 (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the services of a registered nurse (RN) for 8 consecutive hours per day on 2 dates, 12/01/2016 and 12/02/2016. Findings included: During an interview on 12/05/2016 at 2:35 pm with the Scheduler, she verified that there was no RN on the schedule for 12/01/2016 and 12/02/2016. She stated the Minimum Data Set (MDS) Nurse was being counted in staffing and another Registered Nurse's last day of employment with the facility was 12/01/2016. She continued by saying the facility was trying to hire more nurses. During an interview on 12/05/2016 at 3:40 pm with the Acting Director of Nursing she revealed she was not aware there was no registered nurse coverage on 12/01/2016 and 12/02/2016. She explained the MDS nurse was counted in the registered nurse numbers when there was not one. During an interview on 12/06/2016 at with the Administrator, she revealed the facility is trying to	F 354	F 354 Registered Nursing Coverage Beginning on 1/4/2017 a registered nurse will provide onsite coverage daily per the Medicare Guideline. In the event of a call out appropriate action will be taken to ensure an RN covers the facility needs either by the Administrative Nurses-RN's or scheduled floor staff registered nurses. All administrative nurses will be educated on 12/8/16 that upon their role as the RN providing coverage on the floor then they must serve in an administrative capacity/supervisor providing oversight to the patients and clinical staff on duty. On 12/7/16 the Administrator and the Director of Nursing reviewed the staffing schedule to ensure sufficient numbers of staff and registered nursing coverage to provide nursing care to all residents in accordance with resident care plans. On 12/7/16 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff	

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F 354	Continued From page 23 recruit nurses for the facility and she realized she was down a registered nurse. She stated it is her expectation that a RN is schedule for 8 consecutive hours a day, 7 days a week.	F 354	were on duty to meets the care needs of the residents. The Director of Nursing was replace on 12/15/2016. On 12/8/16 the scheduler and Director of Nursing were in-serviced by the administrator related to RN coverage in the facility. Director of Nursing will continue to use staff audit tool to ensure a Registered Nurse is scheduled daily. The new Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents along with assuring the facility residents are provided with 8 consecutive hours of Registered Nursing Coverage. On 12/7/16 the Corporate Consultant in-serviced the Administrator and Director of Nursing regarding Sufficient Staff and the requirement of the 8 hours of consecutive Registered Nursing Coverage. The Sufficient Staff in-service included the following: A. 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. B. The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. On 12/7/16 the Director of Nursing and Administrator reviewed the clinical staffing schedule to assure the sufficient staff were on duty to meets the care needs of the residents. The Director of Nursing was replaced on 12/15/2016. The new	

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F 354	Continued From page 24	F 354	Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to assure the clinical staff are on duty to meets the needs of the residents to include the 8 consecutive hours of registered nursing coverage. The Case Mix Index will be reviewed weekly to assure the acuity of the resident is taken in to account with the clinical staffing patters to meet the needs of the residents. The facility has hired a new RN-Director of Nursing on 12/15/2016, 4 registered nurses, 5 LPNs and 10 Certified Nursing Assistants to fill the vacant position in the current schedule. The open position that remain are 2 full time licensed nurse positions for every other weekend. These positions will be filled by 1/4/16. On 12/8/16, the Administrator and the DON initiated a QI monitoring tool titled Sufficient Staff tool to meet the needs of the residents based upon the acuity level as identified by the Case Mix Index score. The QI monitoring tool will assist with the facility assuring the residents reach their highest practicable physical, mental and psychosocial well-being. The Administrator and the Director of Nursing will utilize the Sufficient Staff tool daily, at the beginning of each shift to include nights and weekends for four weeks, twice weekly for four weeks, weekly for four weeks, and monthly times three months. Any identified issues will be addressed immediately with assuring the proper staff and RN coverage are on duty or the utilization of administrative nurses are pulled to the hall for appropriate coverage.	

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F 354	Continued From page 25	F 354	The Administrator will monitor the Sufficient Staff tool daily to assure the staffing patters are appropriate to meet the needs of the residents care identified by their acuity level from the Case Mix Index report and registered nursing coverage. The administrator will present findings at the monthly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		1/4/17

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before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an

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F 441	Continued From page 27 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility staff failed to remove gloves and wash hands for 1 of 5 residents observed during a medication pass (Resident #10) and failed to maintain a contact precaution sign in a visible location on the door for 1 of 1 resident observed to be on contact precautions (Resident #11). The findings included: 1. On 12/6/16 at 12:05 PM, Nurse #1 was observed to don gloves and administer medications and water flushes via gastric tube for Resident #10. The nurse then picked up a bottle of eye drops from the over bed table and wearing the same gloves administered an eye drop to both of the resident ' s eyes. At the completion of the medication pass, the nurse was asked if she removed her gloves and washed her hands after she gave the medications by gastric tube and before she gave the eye drops and the Nurse stated: " No, I did not. I ' m sorry. " On 12/6/16 at 4:15 PM, the Director of Nursing stated in an interview the nurse should have removed the gloves, washed her hands and donned clean gloves prior to administering the eye drops. 2. On 12/6/16 at 9:20 AM a medication pass was observed for Resident #11. Nurse #2 removed a gown from a rack on the resident ' s door that contained personal protective equipment. There was not a precautions sign on the door to notify staff and visitors the resident required special precautions prior to entering the room. The Nurse stated she had been off for a while and did not know this resident was on isolation. The Nurse was observed to ask the Staff Development	F 441	F 441 Nurse # 1 no longer works at facility. Resident # 10 was assessed on 12/22/16 by Nurse Practitioner with no S\S of eye infection. Contact sign was posted for resident # 11 in a visible place on the door on 12/6/16 by DON. 100% of license nurse were observed administering medications to include via gastrostomy\ J tube and eye medications to ensure gloves are removed and hands are washed when necessary during medication pass to include after gastrostomy tube administration and administration of eye drops initiated on 12/6/16 by Staff Facilitator to be completed by 1/4/2017. The Staff Facilitator immediately retrained the license nurse for any identified areas of concern during the audit. 100% audit of residents on isolation precautions was initiated on 12/6/16 by DON to assure isolation precaution sign to include contact sign is in a visible location on the door. All identified areas of concerns will be immediately addressed by posting appropriate precaution sign by DON during the audit. 100 % of all licensed nurses will be in-serviced by Staff facilitator regarding gloves being removed and hands are washed when necessary during medication pass to include after gastrostomy tube administration and administration of eye drops and posting of	

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F 441	Continued From page 28 Coordinator what kind of isolation the resident was on and was told the resident was on contact precautions for MRSA (Methicillin Resistant Staphylococcus Aureus). On 12/6/16 at 10:45 AM a clear plastic sign was observed to be standing up behind the gowns on the rack on the door of Resident #11 ' s room. Approximately 3 inches of the top of the sign was visible and the information on the sign could not be seen. On 12/6/16 at 10:47 AM an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated the resident had been on contact precautions since re-admitted to the facility on 11/14/16. The SDC stated she did not see the sign on the door and found the sign lying down behind the gowns and she pulled the sign to a standing position. The SDC stated the sign should have been posted on the door. On 12/6/16 at 4:15 PM the Interim Director of Nursing (DON) stated in an interview she did not know why the contact precautions sign was in the box behind the gowns but she went down today and taped the sign to the door. On 12/7/16 at 4:45 PM, the Administrator stated she had seen the contact precautions sign on the resident ' s door since re-admission to the facility. The Administrator stated the sign might have fallen off the door and someone put it in the rack with the gowns.	F 441	appropriate isolation sign in a visible location on the residents door when isolation precaution signs are initiated per policy by 1/4/2017. All newly hired license nurses will be in-serviced by the Staff Facilitator during orientation regarding gloves being removed and hands are washed when necessary during medication pass to include after gastrostomy tube administration and administration of eye drops and posting of appropriate isolation sign in a visible location on the residents door when isolation precaution are initiated per policy. The Medication Pass Audit Tool will be utilized by Staff Facilitator with observation of 10% of license nurses administering medications to residents to include resident #10, to ensure gloves are being removed and hands are washed when necessary during the medication pass to include after gastrostomy administration and eye drop administration weekly x eight weeks then monthly x 1 month. Immediate retraining will be conducted with the licensed nurse for any identified issues observed during the medication pass audits by DON/Staff facilitator. DON/Staff facilitator will perform room rounds for all residents to include resident # 11 requiring isolation precautions to ensure that isolation precaution sign is in a visible location on the door utilizing Isolation Precaution tool weekly X 8weeks and monthly X 1 month. The DON will review and initial the Medication Pass Audit Tool and Isolation Precaution audit tool for appropriate	

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F 441	Continued From page 29	F 441	medication administration to residents to include resident #10 for completion, and to ensure all areas of concern were addressed weekly x eight weeks then monthly x 1 month. The Executive QI committee will meet monthly and review QI Medication Pass Audit Tool and Isolation Precaution audit tool to address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	