| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 345080 | A. BUILDING: _____ B. WING _____ | 3/16/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHAB HICKORY VIEWMON | 220 13TH AVENUE PLACE NW HICKORY, NC |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 514 | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE |

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to document ostomy care for 2 of 2 residents reviewed with ostomies (Resident's #4, #3).

The findings included:

1. Resident #4 was admitted to the facility on 05/18/16 with diagnoses including diabetes and Alzheimer's disease.

Review of Resident #4's physician orders revealed no order for colostomy care and no order for changing the pouching system.

Review of Resident #4's Treatment Administration Record (TAR) from 12/01/16 through 03/16/2017 revealed no record of colostomy care or evidence that the pouching system had been changed.



The above isolated deficiencies pose no actual harm to the residents

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On 03/16/17 at 12:42 PM an interview with Nurse #1 was conducted. Nurse #1 stated that the nursing assistants (NA) were responsible for emptying Resident #4's colostomy pouch and she as the nurse would change the pouching system. Nurse #1 stated that the staff would document on the TAR when the pouching system was changed so that "we could keep up with it every 3 days as the policy stated." Nurse #1 also stated that they documented on the TAR that routine ostomy care was done, because they had to assess the stoma and the surrounding skin. Nurse #1 stated she changed Resident #4's wafer and pouching system and assessed the stoma every 3 to 4 days. She stated the Nurse Aides (NAs) kept her bag emptied and clean and changed the bag if it needed to be changed. She further stated Resident #4 always reminded when it was time to change the wafer.

On 03/16/17 at 1:33 PM an interview was conducted with Certified Medication Aide/Nurse Aide #4 revealed she worked with Resident #4 on the 7:00 AM to 3:00 PM shift at least 5 times a week and she emptied her colostomy bag two times a shift and more often if needed. She stated the nurse changed the system out every 3 to 4 days.

On 03/16/17 at 3:57 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that residents with ostomies wore a pouching system would be changed every 3 to 5 days per the policy and the pouching bag should be emptied or changed at least daily. The DON stated that the ostomy care should be documented on the TAR and they would also be keeping up with the pouching system changes on the TAR so that all staff knew when it was due to be changed next. The DON stated that each staff member had access to the policy when they logged into the electronic medical record and were familiar with where to find the policy if they had any questions. The DON stated that when Resident #4 was admitted to the facility someone should have written an order that read "ostomy care every day and as needed." The order would have been entered into the electronic medical record and that was how the staff would have been prompted to perform the required care. The DON was not aware that Resident #3 did not have an order for ostomy care nor did it appear on the TAR that staff was providing the required care or pouching system changes.

2. Resident # 3 was admitted to the facility on 12/14/16 and discharged from the facility on 02/02/17. Resident #3's diagnoses included: polyp of colon with ostomy status.

Review of Resident #3's physician order revealed no order for ileostomy care and no order for changing the pouching system.

Review of Resident #3's Treatment Administration Record (TAR) dated 01/01/17 through 01/31/17 revealed no record of ileostomy care or evidence that the pouching system had been changed.

On 03/16/17 at 12:42 PM an interview with Nurse #1 was conducted. Nurse #1 stated that the nursing assistants (NA) were responsible for emptying Resident #3's ileostomy pouch and she as the nurse would change the pouching system. Nurse #1 stated that the staff would document on the TAR when the pouching system was changed so that "we could keep up with it every 3 days as the policy stated." Nurse #1 also stated that they documented on the TAR that routine ostomy care was done, because they had to assess the stoma

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and the surrounding skin. Nurse #1 further stated that Resident #3's pouching system was changed much more frequently but the nurses tried their best to leave in on for at least 3 days so his skin would not get irritated or red. Nurse #1 also stated that the NAs would routinely empty Resident #3's pouch and rinse the pouch out before reapplying the pouch to Resident #3.

On 03/16/17 at 3:57 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that residents with ostomies wore a pouching system would be changed every 3 to 5 days per the policy and the pouching bag should be emptied or changed at least daily. The DON stated that the ostomy care should be documented on the TAR and they would also be keeping up with the pouching system changes on the TAR so that all staff knew when it was due to be changed next. The DON stated that each staff member had access to the policy when they logged into the electronic medical record and were familiar with where to find the policy if they had any questions. The DON stated that when Resident #3 was admitted to the facility someone should have written an order that read "ostomy care every day and as needed." The order would have been entered into the electronic medical record and that was how the staff would have been prompted to perform the required care. The DON was not aware that Resident #3 did not have an order for ostomy care nor did it appear on the TAR that staff was providing the required care or pouching system changes.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>1. 483.25 (F323) at J<br>Immediate Jeopardy began on 02/16/17 when Resident #4 eloped from the facility without staff's knowledge that she was outside without supervision. Resident #4 had crossed the parking lot approximately 135 feet in a straight path from the facility front door to the postal box across the road and was brought back to the facility by a visitor that saw her cross the road. The speed limit on the road was 35 miles per hour and the temperature was in the low 50's and overcast. Resident #4 was wearing a long sleeve cotton shirt, slacks, socks and shoes and was assessed by Nurse #2 with no injuries noted. Immediate Jeopardy was removed on 03/16/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D to ensure monitoring of systems put in place and completion of employee training.<br><br>2. 483.75 (F520) at J<br>Immediate Jeopardy began on 02/16/17 when Resident #4 eloped from the facility without staff's knowledge that she was outside without supervision. Resident #4 had crossed the parking lot approximately 135 feet in a straight path from the facility front door to the postal box across the road and was brought back to the facility by a visitor that saw her cross the road. The speed limit on the road was 35 miles per hour and the temperature was in the low 50's and overcast. Resident #4 was wearing a long sleeve cotton shirt, slacks, socks and shoes and was assessed by Nurse #2 with no injuries noted. Immediate Jeopardy was removed on 03/16/17 when the facility provided and implemented a credible | F 000 | | |

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

Electronically Signed | 04/10/2017

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| F 000 | Continued From page 1<br>allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D to ensure monitoring of systems were put in place.<br><br>A partial extended survey was conducted as part of the facility's complaint investigation from 03/14/17 through 03/16/17. Event ID# 546311.<br><br>On 04/10/17 an amended Statement of Deficiencies was provided to the facility because the State Survey Agency made revisions to tags F-323 and F-520. Event ID# 546311. | F 000 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews, the facility failed to maintain a resident's dignity by leaving him in a soiled brief for over an hour for 1 of 4 residents reviewed for dignity and respect (Resident #8).<br><br>The findings included:<br><br>Resident #8 was admitted to the facility on 06/28/11 and was re-admitted on 10/05/15 with diagnoses that included coronary artery disease, heart failure, hypertension, diabetes mellitus type 2, peripheral vascular disease, arthritis, anxiety disorder and depression. | F 241 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F 241<br>Criteria #1<br>On 3/16/17 the Director of Nursing validated that Resident #8 received | 4/18/17 |

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| F 241 | Continued From page 2<br><br>Review of Resident #8's quarterly MDS dated 01/27/17 revealed that he was cognitively intact and required extensive to total assistance of 1 to 2 persons for all ADL except eating and was totally dependent on staff for bathing.<br><br>Review of Resident #8's CAA summary dated 02/09/17 revealed he was frequently incontinent of urine and always incontinent of bowel and dependent on staff for extensive to total care for all ADL.<br><br>Review of Resident #8's care plan dated 02/10/17 revealed that he had an ADL self-care deficit related to his limited mobility and required extensive staff assistance to total dependence for all ADL.<br><br>Interview 03/16/17 at 9:08 AM with nurse aide (NA) #4 revealed that residents did not get incontinence care every 2 hours as they should. NA #4 stated it was now 9:10 AM and incontinence care had not been provided for the residents on the hall. She stated that with 2 NAs and 1 pulled to assist with breakfast there was not enough help to get incontinence care done and by the time they got to them some of the residents were really wet and soiled.<br><br>Interview 03/16/17 at 9:20 AM with Resident #8 revealed that he had waited several times for over an hour to get assistance with incontinent care. He further stated that approximately 2 weeks ago, on evening shift, he laid with bowel movement in his brief for an hour and 10 minutes waiting for someone to assist him with incontinent care. He stated "can you imagine how humiliating and degrading it is to lay in your own | F 241 | incontinent care following an episode of bowel incontinence. A skin assessment was completed for Resident #8 by the Charge Nurse on 3/14/17 and skin integrity remains intact. Nursing Staff have been re-educated regarding providing incontinent care with dignity and respect by the Director of Nursing or Nurse Managers by 4/18/17.<br>Criteria #2<br>Residents receiving incontinent care have the potential to be affected by the alleged deficient practice. The Nurse Managers conducted an audit and interview of current residents to evaluate care is being provided with dignity. This audit was completed by 4/18/17. Opportunities were corrected as identified.<br>Criteria #3<br>Nursing Staff have been re-educated by the Director of Nursing or Nurse Managers on providing incontinent care with dignity and respect. This education was completed by 4/18/17. The Director of Nursing or Nurse Managers will make 10 random observations of residents receiving incontinent care, per week for 12 weeks, to validate residents are receiving incontinent care with dignity and respect. Opportunities will be corrected daily as identified.<br>Criteria #4<br>The Director of Nursing will report the results of these observations to the QAPI committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of | |

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| F 241 | Continued From page 3<br>stool for an hour and 10 minutes and be helpless to do anything about it?" Resident #8 stated that call light response time had been discussed in Resident Council meetings several months but nothing had changed.<br><br>Interview 03/16/17 at 9:50 AM with NA #4 revealed that it was very likely that residents would wait for incontinence care on the evening shift because there was not enough help. She stated that evening shift was always short staffed with NAs and that NAs from day shift were staying over and NAs from night shift were coming in early to cover evenings. NA #4 stated they had done the best that they could with the limited staffing they had on evenings.<br><br>Interview 03/16/17 at 10:03 AM with nurse #2 revealed that most days they worked short on evening shifts. She stated that there was not enough NAs on evening shift to cover the schedule. Nurse #2 stated they had done the best that they could for the residents with the help they were given. She stated that the nurses and medication aides were assisting the NAs but they had their duties to complete and all the care sometimes could not get done. She stated that showers, oral care and incontinence care were not completed as needed or scheduled.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed she expected the NAs to change residents who needed incontinence care every 2 hours or as needed. She further stated she would have expected the NAs to change Resident #8 out of his soiled brief in much less time than an hour and 10 minutes. She stated that it was her expectation that all residents were treated with dignity and respect and that no | F 241 | trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee will evaluate effectiveness of the plan and make recommendations as required. | |

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| F 241 | Continued From page 4<br>resident would feel humiliated or degraded. | F 241 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced | F 278 | | 4/18/17 |

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| F 278 | Continued From page 5<br>by:<br>Based on record review and staff interviews the facility failed to accurately code the minimum data set to reflect the resident's ostomy status for 2 of 3 residents (Resident # 3 and Resident # 6).<br><br>The findings included:<br><br>1. Resident #3 admitted to the facility on 12/14/16 and discharged from the facility on 02/02/17 with diagnoses that included: polyps of colon with ostomy status.<br><br>Review of the admission comprehensive minimum data set (MDS) dated 12/21/16 revealed that Resident #3 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #3 had an ostomy and was always continent of bowel.<br><br>On 03/15/17 at 4:29 PM an interview with MDS Nurse #1 was conducted and revealed that she had been completing MDS assessments for many years. The MDS Nurse #1 stated that if a resident had an ostomy including urostomy, ileostomy, or colostomy that would be coded in section H of the MDS. The MDS Nurse #1 stated that if a resident had one of those ostomies then the bowel status would be coded as "always continent." MDS Nurse #2 was present during the interview and indicated by shaking her head "no" that she did not think that the bowel status should be coded as "always continent." MDS Nurse #1 reviewed the Resident Assessment Instrument (RAI) and stated that Resident #3's bowel status should have been coded as "not rated" instead of "always continent" and she would correct the MDS right away. | F 278 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F278<br><br>Criteria 1<br>Corrective action was accomplished for the alleged deficient practice for Resident #3 MDS with ARD 12/21/16 to accurately reflect bowel continence status and Resident #6 with ARD 2/20/17 to accurately reflect bladder and bowel appliances. Modifications of these assessments were completed on 3/20/17 to correct MDS coding errors.<br><br>Criteria 2<br>All Residents have the potential to be affected by this alleged deficient practice. An audit of current residents having an MDS completed during the last 14 days was completed by the Resident Care Management Director to verify accurate assessment of those residents bowel continence and bladder and bowel appliances. Corrections were completed as identified per the RAI manual guidelines .This audit was completed by 4/8/2017.<br><br>Criteria 3 | |

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| F 278 | Continued From page 6<br><br>On 03/16/17 at 3:57 PM an interview with Director of Nursing (DON) was conducted and revealed that she expected the MDS to be completed accurately to reflect the resident's current status.<br>2. Resident #6 was admitted to the facility on 09/09/13 and re-admitted on 04/12/16 with diagnoses that included dementia.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 02/20/17 revealed that Resident #6 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed Resident #6 was coded as having an ostomy and was always incontinent of bowel and bladder.<br><br>Interview on 03/16/17 at 5:00 PM with MDS nurse #2 revealed that Resident #6 did not have an ostomy of any type. MDS nurse #2 stated that she had taken care of Resident #6 while working as a nurse on the hall and knew that she did not have an ostomy and had been coded incorrectly as having an ostomy by MDS nurse #1. MDS nurse #1 came in during the interview and stated that it was an error and they would correct the MDS right away.<br><br>On 03/16/17 at 5:19 PM an interview with the Director of Nursing (DON) was conducted and revealed that she expected the MDS to be completed accurately to reflect the resident's current status. | F 278 | The District Director of Care Management (DDCM) re-educated the Resident Care Management Director (RCMD) and MDS staff on accurate MDS coding related to bowel continence and bladder and bowel appliance per the RAI manual. The RCMD will randomly review 5 completed MDSs weekly for 12 weeks to verify accurate coding of bowel continence and bladder and bowel appliances. Opportunities will be corrected as identified as a result of these audits.<br><br>Criteria 4<br>The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility QAPI meeting. The committee will make changes or recommendations as indicated.<br><br>Date of compliance 4/18/2017 | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, | F 282 | | 4/18/17 |

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| F 282 | Continued From page 7<br>as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and resident and staff interviews, the facility failed to provide restorative nursing care for ambulation, splint management and passive range of motion exercises as outlined in the care plan for 1 out of 10 resident (Resident #6) reviewed for care planned interventions.<br><br>The findings included:<br><br>Resident #6 was admitted to the facility on 09/09/13 and re-admitted on 01/12/16 with diagnoses which included cerebral infarction, hemiplegia affecting the right side, difficulty walking, muscle weakness, and dementia.<br><br>Review of the Minimum Data Set (MDS) dated 02/20/17 for Resident #6 revealed that she was cognitively intact and required extensive to total assistance with all Activities of Daily Living.<br><br>Review of the care plan dated 03/02/17 revealed Resident #6 was care planned for receiving restorative care splint/brace assistance, gentle passive range of motion to the right upper extremity and ambulation 7 days a week. The goal was for the resident to achieve the highest level of optimal functioning over the next 90 days. The interventions for the resident included: allow ample time, allow rest periods and do not rush, do not force limbs/joints, monitor for increased | F 282 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F 282<br>Criteria #1<br>Resident #6 was evaluated by the Rehab Staff by 4/18/17 and a treatment plan developed to include splinting, range of motion and development of a Restorative Nursing Program for ongoing management<br>Criteria #2<br>Residents with care planned interventions for restorative nursing are at risk of being affected by this alleged deficient practice. The Director of Nursing and Nurse Managers completed an audit of residents with care planned interventions for restorative nursing to evaluate ongoing needs and accuracy. This audit was completed by 4/18/17. Opportunities were corrected as identified.<br>Criteria #3<br>The Director of Nursing or Nurse | |

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| F 282 | Continued From page 8<br>weakness, stiffness, and pain and inform nurse, encourage/praise when goal is accomplished or attempted, evaluate progress every month and as needed, explain all tasks using terms, gestures the resident can understand, perform restorative care per order and do not force or rush.<br><br>A review of Resident #6's restorative care service delivery record revealed she received restorative care 2 days in February (care was ordered to start 2/21/17 and be done 7 days a week) and missed 6 days. The record for March revealed that she had received restorative care 10 out of 16 days, and missed 6 days.<br><br>Interview 03/16/17 at 8:37 AM with Resident #6 revealed she was getting restorative nursing but she was not getting it every day like it was ordered. She stated the restorative aides were working on the hall as nurses aides (NAs) and could not get to her every day.<br><br>Interview 03/15/17 at 2:34 PM with Restorative Aides #1 and #2 revealed they were pulled to the hall to work as NAs 5 out of 7 days per week and on these days restorative nursing care was not being provided. They stated that they were aware of the residents on their list not getting care and were aware of the restorative orders for Resident #6. They both stated on these days they were reporting their inability to do care to the Restorative Nurse who was also the MDS nurse #2.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that it was her expectation that residents get restorative care as ordered. She stated that the restorative aides were expected to report to the restorative nurse | F 282 | Managers will re-educate Nursing Staff on implementation of care planned restorative nursing to include the Restorative Nursing Aide to complete care planned Restorative Nursing interventions daily as assigned. In the event a Restorative Aide is unavailable to complete the assigned tasks the Administrator will be notified and alternative staffing will be secured for completion of these interventions. This education was completed by 4/18/17.<br>The Director of Nursing or Nurse Managers will randomly observe 10 residents weekly for 12 weeks to verify care planned interventions are in place. Opportunities will be corrected as identified as a result of these audits Criteria #4<br>The Director of Nursing will report the results of these observations to the QAPI committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee will evaluate effectiveness of the plan and make recommendations as required. | |

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| F 282 | Continued From page 9<br>when services were not provided to residents. | F 282 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers and bed baths as scheduled and incontinent care for 3 of 4 residents reviewed for Activities of Daily Living (ADL) (Residents #6, #7 and #8).<br><br>The findings included:<br><br>1. Resident #6 was admitted to the facility on 09/09/13 and was re-admitted on 04/12/16 with diagnoses that included fractured right femur, cerebrovascular accident (CVA), and hemiplegia affecting right side, type 2 diabetes mellitus, anxiety disorder, congestive heart disease, and dementia without behaviors.<br><br>Review of Resident #6's quarterly Minimum Data Set (MDS) dated 02/20/17 revealed an assessment of intact cognition. The MDS indicated Resident #6 required extensive to total assistance of 1 to 2 persons with all ADL.<br><br>Review of Resident #6's care plan dated 03/02/17 revealed that she was dependent on staff assistance for all ADL related to her diagnoses of CVA and right hemiparesis. | F 312 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F312<br>Criteria 1<br>On 3/17/17 the Director of Nursing validated that Residents #6 received a shower according to her preference.<br>On 3/17/17 the Director of Nursing validated that Resident #7 receiving a shower according her preference.<br>On 3/16/17 the Director of Nursing validated that Resident #8 received incontinent care following an episode of bowel incontinence. On 3/17/17 the Director of Nursing validated that Resident #8 received a shower according to his preference on.<br><br>Criteria 2<br>Current residents requiring assistance | 4/18/17 |

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| F 312 | Continued From page 10<br>Interview 03/16/17 at 10:18 AM with Resident #6 revealed that she was not getting her showers 2 times weekly. She stated she maybe got 1 shower per week because there was not enough staff to provide them 2 times a week.<br><br>Review of the ADL bathing documentation for February, 2017 revealed that Resident #6 received only 4 baths for the month of February and 1 bath from March 1 through March 16, 2017.<br><br>Interview 03/15/16 at 9:00 AM with nurse aide (NA) #1 revealed that they often worked short staffed and showers were not done as scheduled.<br><br>Interview 03/15/17 at 11:53 AM with nurse #3 revealed that they were almost always short staffed and this had been a problem for months. Nurse #3 stated that showers were not being done as scheduled.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that her expectation was for all residents to receive their showers as scheduled.<br><br>Interview 03/16/17 at 5:15 PM with the Administrator revealed that her expectation was that all residents receive assistance with ADL according to their schedule for showers.<br><br>2. Resident #7 was admitted to the facility on 01/20/16, readmitted on 03/29/16 and readmitted again on 11/28/16 with diagnoses that included atrial fibrillation, heart failure, diabetes mellitus type 2 and obstructive sleep apnea.<br><br>Review of Resident #7's annual MDS dated | F 312 | with incontinent care and showers have the potential to be affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of residents requiring assistance with incontinent care and showers to validate current preferences and completion of showers as required according to these preferences. This audit was completed by 4/18/17 and opportunities were corrected as identified.<br><br>Criteria 3<br>Nursing Staff were re-educated by 4/18/17 by the Director of Nursing and Nurse Managers on the expectation of providing residents with assistance of completion of ADLs with a focus on completion of showers according to the resident's preference and completion of incontinent care as required.<br><br>The Nurse Managers will randomly observe 10 residents per week, who require assistance with showers and incontinent care for 12 weeks, to validate completion of ADL assistance including showers and incontinent care. Opportunities will be corrected as identified during these audits.<br><br>Criteria 4<br><br>The Director of Nursing will report the results of these observations to the QAPI committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program | |

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| F 312 | Continued From page 11<br>01/29/17 revealed an assessment of intact cognition. The MDS indicated Resident #7 required extensive assistance of 1 person with ADL and was totally dependent on staff for bathing.<br><br>Review of Resident #7's care plan dated 01/29/17 revealed that she required staff assistance and intervention for completion of all ADL needs.<br><br>Interview 03/16/17 at 8:56 AM with Resident #7 revealed that she was not getting her bed baths 2 times per week as she was scheduled. She stated that the staff worked hard but there was just not enough to meet the needs of the residents. She stated that she had told the Administrator that there was not enough help to get all the residents bathed and showered, but nothing had changed.<br><br>Review of the ADL bathing documentation for February, 2017 revealed that Resident #7 received only 4 baths for the month of February and 2 baths from March 1 through March 16, 2017.<br><br>Interview 03/16/17 at 9:08 AM with NA #4 revealed that they often work short staffed and showers and bed baths are not done as scheduled. She stated that it was hard to get everything done on first shift and to assist in the dining room with 2 meals.<br><br>Interview 03/16/17 at 11:53 AM with nurse #2 revealed that they were almost always short staffed and especially with NAs and it made it hard to get all the work done. There were residents who had requested 3 showers per week and they were doing good to get 1 or 2. The | F 312 | including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee will evaluate effectiveness of the plan and make recommendations as required. | |

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| F 312 | Continued From page 12 | F 312 | | |

Director of Nursing (DON) was aware that residents were not receiving showers as they had requested.

Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that her expectation was for all residents to receive their showers as scheduled.

Interview 03/16/17 at 5:15 PM with the Administrator revealed that her expectation was that all residents received assistance with ADL according to their schedules for showers.

3. Resident #8 was admitted to the facility on 06/28/11 and was re-admitted on 10/05/15 with diagnoses that included coronary artery disease, heart failure, hypertension, diabetes mellitus type 2, peripheral vascular disease, arthritis, anxiety disorder and depression.

Review of Resident #8's quarterly MDS dated 01/27/17 revealed that he was cognitively intact and required extensive to total assistance of 1 to 2 persons for all ADL except eating and was totally dependent for bathing.

Review of Resident #8's care plan dated 02/10/17 revealed that he had an ADL self-care deficit related to his limited mobility and required staff assistance to total dependence for all ADL.

Interview 03/16/17 at 9:20 AM with Resident #8 revealed he was not getting showers 2 times per week. He stated he got showers when the NAs had time to give him one. He stated that he regularly attended the Resident Council meeting and they had discussed showers not getting done several months but nothing had changed. He

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| F 312 | Continued From page 13<br>stated that Administration was aware of the problem.<br><br>Review of the ADL bathing documentation for February, 2017 revealed that Resident #8 received only 5 baths for the month of February and 1 bath from March 1 through March 16, 2017.<br><br>Interview 03/16/17 at 9:08 AM with NA #4 revealed that they often worked short staffed and showers and bed baths were not done as scheduled. She stated that it was hard to get everything done on first shift and assist in the dining room with 2 meals.<br><br>Interview 03/16/17 at 11:53 AM with nurse #2 revealed that they were almost always short staffed and especially with NAs and it made it hard to get all the work done. There were residents who had requested 3 showers per week and they were doing good to get 1 or 2. The Director of Nursing (DON) was aware that residents were not receiving showers as they had requested.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that her expectation was for all residents to receive their showers as scheduled.<br><br>Interview 03/16/17 at 5:15 PM with the Administrator revealed that her expectation was that all residents receive assistance with ADL according to their schedule for showers. | F 312 | | |
| F 318 SS=D | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION | F 318 | | 4/18/17 |

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| F 318 | Continued From page 14<br>(c) Mobility.<br><br>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews and resident and staff interviews the facility failed to provide restorative nursing care for splint management and passive range of motion exercises for 1 out of 1 resident (Resident #6) reviewed for restorative care.<br><br>The findings included:<br><br>Resident #6 was admitted to the facility on 09/09/13 and re-admitted on 01/12/16 with diagnoses which included cerebral infarction, hemiplegia affecting the right side, difficulty walking, muscle weakness, and dementia.<br><br>Review of the Minimum Data Set (MDS) dated 02/20/17 for Resident #6 revealed that she was cognitively intact and required extensive to total assistance with all ADL.<br><br>Review of the care plan dated 01/29/17 for Resident #6 revealed that she was care planned for restorative care for gentle passive range of motion to right upper extremity 7 days a week. Resident #6 was also care planned for right | F 318 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F318<br><br>Criteria 1<br>Resident #6 was evaluated by the Rehab Staff by 4/18/17 and a treatment plan developed to include splinting, range of motion and development of a Restorative Nursing Program for ongoing management.<br>Criteria 2<br>Residents with contractures have the potential to be affected by this alleged deficient practice. An audit of current residents with contractures was conducted by the Rehab Staff by 4/18/17. | |

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| F 318 | Continued From page 15<br>wrist/hand/finger splint and increase splint use to 6 hours daily 7 days a week.<br><br>Interview 03/16/17 at 8:37 AM with Resident #6 revealed she was getting restorative nursing but she was not getting it every day like it was ordered. She stated the restorative aides were working on the hall as nursing aides (NAs) and could not get to her every day.<br><br>A review of Resident #6's restorative care service delivery record revealed she received restorative care 2 days in February (care was ordered to start 2/21/17 and be done 7 days a week) and missed 6 days. The record for March revealed that she had received restorative care 10 out of 16 days, and missed 6 days.<br><br>Interview 03/15/17 at 9:00 AM with nurse aide (NA) #1 who was also responsible for the schedule revealed that there is not enough staff to cover the schedule. She stated that the Restorative Aides had been pulled to the hall and worked as NAs 5 out of 7 days and restorative care was not being provided to the residents.<br><br>Interview 03/15/17 at 11:53 AM with Nurse #2 revealed the Restorative Aides were being pulled to the hall to work as NAs and residents were not receiving restorative nursing care.<br><br>Interview 03/15/17 at 2:34 PM with Restorative Aides #1 and #2 revealed they were pulled to the hall to work as NAs 5 out of 7 days per week and on these days restorative nursing care was not being provided. They both stated on these days they were reporting their inability to do care to the Restorative Nurse who was also the MDS nurse #2. | F 318 | Based on the results of this audit, an individualized treatment plan was developed to include splinting and range of motion where clinically appropriate. Ongoing Restorative Nursing Programs will be developed and implemented as therapy treatment plans are completed.<br>Criteria 3<br>Licensed Nurses were re-educated by the Staff Development Coordinator regarding the assessment of residents with decreased range of motion and contractures to include therapy referral for evaluation and ongoing treatment by Restorative Nursing. The re-education was completed by 4/18/17. The Rehab Manager or Nurse Manager will randomly audit 5 residents weekly for 12 weeks with contractures to ensure range of motion and splinting is completed as clinically indicated. Opportunities will be corrected as identified.<br>Criteria 4<br>The Rehab Director will report the results of these audits and monitoring to the QAPI committee for three months, quarterly, and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. | |

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| F 318 | Continued From page 16<br><br>Interview 03/15/17 at 3:02 PM with NA #2 revealed restorative care had not been done for residents because the restorative aides #1 and #2 had been pulled to work the halls as NAs.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that it was her expectation that residents get restorative care as ordered. | F 318 | | |
| F 323 SS=J | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(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.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. | F 323 | | 4/18/17 |

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| F 323 | Continued From page 17<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to prevent 1 of 9 cognitively impaired residents, who were assessed as being at risk for elopement, from exiting the facility and leaving the facility's grounds (Resident #4).<br><br>Immediate Jeopardy began on 02/16/17 when Resident #4 eloped from the facility without staff's knowledge that she was outside without supervision. Resident #4 had crossed the parking lot approximately 135 feet in a straight path from the facility front door to the postal box across the road and was brought back to the facility by a visitor that saw her cross the road. The speed limit on the road was 35 miles per hour and the temperature was in the low 50's and overcast. Resident #4 was wearing a long sleeve cotton shirt, slacks, socks and shoes and was assessed by Nurse #2 with no injuries noted. Immediate Jeopardy was removed on 03/16/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D to ensure monitoring of systems put in place and completion of employee training.<br><br>The findings included:<br><br>Review of the facility's "Resident Elopement" Policy and Procedure with release/revision date of June 2007 specified the following:<br>"The facility will provide a safe environment and preventive measures for elopement. Nursing personnel must report and investigate all reports of missing residents."<br>"It is the responsibility of all personnel to report | F 323 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F323<br><br>1. Resident #4 was assessed as being at risk for elopement and a Wanderguard was initiated on 08/21/16 . On 2/16/17 at approximately 5:30pm Resident #4 was assisted back into the facility at the building□s front door by Nurse #3. As Resident #4 re-entered the facility, in her wheel chair, the wander guard she was wearing sounded and the door immediately locked. A visitor reported to Nurse #3 that she observed Resident #4 cross the street, in her wheel chair and rolled herself back into the facility parking lot, prior to being assisted back into the facility.<br>Nurse #3 immediately completed a Head to Toe Assessment of Resident #1with no injuries noted. An updated Elopement Assessment was completed for Resident #4 and the care plan was reviewed and updates by the Director of Nursing on 2/16/17. The Director of Nursing validated the placement and function of the Wanderguard for Resident #4. | |

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| F 323 | Continued From page 18<br>any resident attempting to leave the premises, or suspected of being missing, to the charge nurse and document the occurrence."<br><br>Resident #4 was admitted to the facility on 05/18/16 with diagnoses including diabetes and Alzheimer's disease.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 02/17/17 revealed Resident #4 was severely cognitively impaired. The MDS further indicated Resident #1 had wandering behavior 1 to 3 days during the assessment period.<br><br>Review of the care plan with a creation date of 08/30/16 and last updated date of 02/17/17 revealed Resident #4 was an elopement/wanderer related to being disoriented to place, impaired safety awareness and elopement that occurred on 02/16/17. The goal was for her safety to be maintained through the review date. The interventions included: identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Wander alert checks daily.<br><br>Review of Nurse's notes:<br><br>08/21/16 4:05 PM Resident #4 observed by this nurse attempting to go out front door of facility. Resident #1 is alert with diagnoses of dementia. Resident stated to this nurse, "I'm going home." Resident was easily redirected." Wanderguard bracelet placed on resident for elopement risk and safety. Will continue to monitor.<br><br>08/27/16 2:16 PM Resident pleasantly confused. | F 323 | Increased supervision was initiated for Resident #4 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented on the flow record by the Charge Nurse for 72 hours following the incident.<br>Nurse #3 notified Resident #4□s Responsible Party and Physician regarding Resident #4 exiting the facility, physical assessment following the event and plan for increased monitoring on 2/16/17. No new Physician□s Orders were received. An Incident report was completed by Nurse #3 on 2/16/17 and an investigation was completed by the Director of Nursing on 2/16/17 who interviewed Resident #4 and determined that she exited the Facility via the front door by entering the Wanderguard code into the key pad.<br>Since 2/16/17 the Restorative Aides have validated the placement and function of Resident #4□s Wanderguard daily and documented on the Wanderguard Log.<br>On 3/16/17 Incident and Accident reports for the last 90 days were reviewed by the Director of Nursing and Administrator and it was determined there were no other unsupervised exits reported for Resident #4. There were no other unsupervised exits reported for other residents assessed at risk for elopement during the last 90 days. To the knowledge of Facility Staff and Leadership, Resident #4 has had no other instances of exiting the facility without supervision since 2/16/17.<br>2. The code for the Wanderguard System was changed by the Maintenance | |

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| F 323 | Continued From page 19<br>Alert to self but disoriented to place, time and situation. Redirected from exit doors multiple times. No distress noted.<br><br>09/08/16 3:35 PM Resident placed herself on the floor in front of her wheelchair and began to cut her wanderguard off with a pair of nail clippers. She was placed back into her chair and wanderguard was replaced and nail clippers were taken from her. No injuries were noted from her cutting off the wander guard.<br><br>09/16/16 2:36 PM Resident is alert with confusion, attempts to leave the facility by shaking the front door until she gets it open. She also has started putting herself on the floor from her wheelchair.<br><br>11/17/16 7:13 PM Resident continually wandering around the facility. Resident walking around with her wanderguard in hand. Resident knows how to turn chair alarm off. Asked therapy to reassess her for independent status.<br><br>02/16/17 5:30 PM Resident, in a wheelchair, was brought into the facility building by a staff member. A visitor was following close behind and stated, "She had went across the road and I had stopped my car to allow her to cross back into the parking lot." Upon resident entering into building, wanderguard sounded at the door immediately locked. The resident stated, "If you wait long enough someone will open the door for you." Entered facility. Full assessment with no injury presented. Alert and verbal, disoriented to time and place. Immediate elopement protocol placed into action, monitoring resident's location every 15 minutes, to continue for 72 hours. | F 323 | Director on 2/16/17 and again on 3/15/17. The Maintenance Director completed a review of the Wanderguard System including validation of properly functioning Wanderguard keypads and alarms for all facility doors on 2/16/17 and again on 3/15/17. The Maintenance Director or Administrator will continue to monitor the Wanderguard System for all facility doors daily and document on the Wanderguard Log.<br>The Director of Nursing and Nurse Managers completed an audit of all current residents with Wanderguards and validated placement and function of each device on 2/16/17 and again on 3/151/7.<br>On 2/17/17 and 3/16/17 the Director of Nursing and Nurse Managers conducted an audit of all current residents at risk for elopement to include a review of current Elopement Assessments for accuracy, validation of Wanderguard placement and operation as required, validation of Physician□s Orders to include checking placement of current Wanderguards every shift and function of current Wanderguards daily. These checks for placement and function will be documented by the Charge Nurse on the Medication Administration Record.<br>Elopement care plans were reviewed and validated on 2/17/17 by the Nurse Managers.<br>All care plans of Residents with Wanderguard were updated on 2/17/17 and on 3/16/17 to reflect required interventions based on the review of Elopement assessments by the Nurse Managers. | |

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| F 323 | Continued From page 20<br><br>Review of the facility Incident/Accident Report dated 02/16/17 at 5:30 PM revealed Resident #4 exited the facility, elopement - no injury. Investigation follow-up - Resident was in wheelchair and seen by mailbox, a visitor observed resident cross the street. Staff re-directed resident in the facility on entry alarm sounded wander guard functioning properly. Resident stated she was going to check mail. Asked Resident how she was able to get out of the door, she replied, "You just have to wait and someone will open the door for you." Past Interventions attempted - Sign on door for visitors to see nurse for residents - do not open door for residents. Recommendations - New elopement assessment completed. Wanderguard checked for proper functioning. All doors checked by Maintenance Director. Code to wanderguard changed (front door). Resident placed on every 15 minute checks for 72 hours than 1 hour until placement can be found at a locked unit.<br><br>An interview conducted on 03/15/17 at 11:38 AM with Nurse #2 revealed on 02/16/17 she was walking to the nurse's desk in the front lobby and saw a visitor pushing Resident #4 in her wheelchair in the parking lot toward the front door of the facility. She stated she immediately went outside to see why Resident #4 was outside. Nurse #2 stated the visitor told her she was coming to the facility and had to stop her car in front of the facility, on the main road to let Resident #4 come back across the road to the facility parking lot and she parked her car and brought Resident #4 back to the facility. She stated Resident #4 had gone approximately 135 feet from the facility across the street and 135 feet back to the facility. She stated the weather | F 323 | Beginning on 3/16/17, the Admissions Director will review referrals for potential admissions with identified exit seeking behaviors with the Director of Nursing and Administrator prior to offering placement to ensure proper placement. The Director of Nursing and Nurse Managers will continue to review new admissions and readmission daily during the Clinical Morning Meeting to validate accurate elopement assessments and care plans as required. The Director of Nursing and Nurse Managers will review current residents assessed at risk for elopement monthly to validate accurate assessments and care plans.<br>Beginning on 3/16/17 any Resident elopement will be reported immediately to the Facility□s Administrator or Director of Nursing and an Incident and Accident report will be completed.<br>3. On 3/16/17 The Director of Nursing and Nurse Managers re-educated all current Facility Staff regarding the facility policy for Elopement. On 3/15/17 the Director of Nursing and Nurse Managers educated all current facility staff regarding changing the code on the Wanderguard System and keeping this code discrete which includes not sharing with families, visitors or residents and to report any deviations from this process to the Administrator or the Director of Nursing. On 3/15/17 the Maintenance Director changed the code for the Wanderguard System. On 3/15/17 the Administrator and the Maintenance Director implemented a process for changing the code for the Wanderguard System | |

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| F 323 | Continued From page 21<br>was gloomy and in the low 50's and Resident #4 had on a long sleeved cotton shirt, slacks and tennis shoes. Nurse #2 stated when they approached the front door it locked due to Resident #4's wander guard and staff inside had to unlock the door to let them in. Nurse #2 stated she assessed Resident #4 and found no injuries, placed her on elopement precautions protocol, informed the Administrator, who was in the building and called the Director of Nursing per Administrator's order. Nurse #2 further stated she did not hear Resident #4's wanderguard alarm go off and was not aware she was out of the building until she saw her outside and did not know how she went out without the alarm sounding.<br><br>An interview was conducted on 03/15/17 at 3:15 PM with Restorative Aide (RA) #2 revealed he worked on 02/16/17 with Resident #4 on the 3:00 PM to 11:00 PM shift. He stated he saw Resident #4 eating supper in the main dining room around 5:00 PM and did not hear an alarm go off and did not know she had gone out of the building. RA #2 stated Resident #4 was her baseline during supper and wasn't anxious or in a hurry to leave the dining room. He stated Resident #4 would sit in the front lobby after supper and watch the news and she would wander throughout the building and would try to go out the front door with visitors and would tell him she wanted to go home. RA #2 stated she had gone out the front door one time before and her alarm went off and he brought her right back into the building. RA #2 further stated some of the alert and oriented residents that sat in the front lobby knew the code and would let visitors in if the door was locked.<br><br>Interview conducted with the DON at 3:46 PM on 03/15/17 revealed she was not in building on | F 323 | monthly or as needed and included this as part of the staff education.<br>No staff shall work after 3/15/17 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 3/15/17.<br>The Administrator, Director of Nursing or Nurse Manager will randomly interview 5 staff members 3 times per week for 12 weeks to ensure the Wanderguard code is kept discrete. The Administrator will monitor the Door logs weekly for 12 weeks to ensure the Wanderguard System is monitored at each door daily for proper function. The Director of Nursing and Nurse Managers will monitor residents with wanderguards weekly for 12 weeks to validate documentation of effective placement and function of the wandergurds.<br>4. The Administrator will report the results of these audits weekly for 12 weeks during the QAPI Meeting and then monthly thereafter. The committee will review these results and make recommendations as required. | |

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02/16/17 when Resident #4 eloped but she was called and notified by Nurse #1 and came to the facility later that evening. The DON stated she interviewed Nurse #1 and Resident #4 about the incident the following day. She stated Resident #4 told her she was going to check the mail and when she asked her how she got out the door Resident #4 told her if you watched long enough you could press those buttons and go out. The DON stated she assumed she had watched staff put in the code or heard staff telling visitors and staff the code and she knew how to go out without the alarm sounding. The DON stated she interviewed all staff and none of them heard the alarm go off when Resident #4 exited the building. She stated she called the Maintenance Director and he came in and reset the code for the front door. The DON stated there was no one at the reception desk in the evenings after supper but the nurses were in and out of the nurse's desk and were able to observe the residents that liked to sit in the front lobby in the evenings.

During an interview conducted on 03/15/17 at 5:00 PM the Administrator stated she was working in the conference room on 02/16/17 around 5:30 - 6:00 PM when Nurse #2 came in and informed her Resident #4 had eloped, crossed the road and was pushed back to the facility by a visitor. The Administrator stated she informed her to call the DON and complete an incident report. The Administrator stated she was not aware Resident #4 had tried to exit the building in the past. She stated the investigation conducted revealed staff would tell other staff or visitors the code to unlock the front door and Resident #4 had to know the code to exit without the alarm from her wander guard sounding. The Administrator stated Resident #4's wanderguard

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was functioning properly because it the locked the door when they tried to re-enter the building and the Maintenance Director checked it that evening and the alarm sounded when the code for the door wasn't put in first.

On 03/15/17 at 5:20 PM an interview with Resident #8, who was alert and oriented, was conducted. During this interview Resident #8 stated he was aware of the code to unlock the facility's front door to exit the facility. The resident stated he knew the facility's front door exit code by hearing staff yell the code out to each other. During this interview Resident #8 correctly provided the current code to unlock the facility's front door to the surveyor.

Observations made on 03/15/17 at 8:35 AM, 03/15/17 at 3:30 PM and 03/16 17 at 4:30 PM revealed Resident #4 in her room talking with her roommate and watching television. Her wanderguard was observed on her left ankle each observation.

The Administrator and DON were informed of Immediate Jeopardy on 03/15/17 at 6:38 PM.

On 03/16/17 at 6:35 PM, the facility provided the following Credible Allegation of Compliance:

1. Resident #1 was assessed as being at risk for elopement and a Wanderguard was initiated on 08/21/16. On 2/16/17 at approximately 5:30pm Resident #1 was assisted back into the facility at the building's front door by Nurse #3. As Resident #1 re-entered the facility, in her wheel chair, the wander guard she was wearing sounded and the door immediately locked. A visitor reported to Nurse #3 that she observed

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Resident #1 cross the street, in her wheel chair and rolled herself back into the facility parking lot, prior to being assisted back into the facility. Nurse #3 immediately completed a Head to Toe Assessment of Resident #1 with no injuries noted. An updated Elopement Assessment was completed for Resident #1 and the care plan was reviewed and updates by the Director of Nursing on 2/16/17. The Director of Nursing validated the placement and function of the Wanderguard for Resident #1. Increased supervision was initiated for Resident #1 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented on the flow record by the Charge Nurse for 72 hours following the incident.

Nurse #3 notified Resident #1's Responsible Party and Physician regarding Resident #1 exiting the facility, physical assessment following the event and plan for increased monitoring on 2/16/17. No new Physician's Orders were received. An Incident report was completed by Nurse #3 on 2/16/17 and an investigation was completed by the Director of Nursing on 2/16/17 who interviewed Resident #1 and determined that she exited the Facility via the front door by entering the Wanderguard code into the key pad.

Since 2/16/17 the Restorative Aides have validated the placement and function of Resident #1's Wanderguard daily and documented on the Wanderguard Log.

On 3/16/17 Incident and Accident reports for the last 90 days were reviewed by the Director of Nursing and Administrator and it was determined there were no other unsupervised exits reported for Resident #1. There were no other unsupervised exits reported for other residents assessed at risk for elopement during the last 90 days. To the knowledge of Facility Staff and

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Leadership, Resident #1 has had no other instances of exiting the facility without supervision since 2/16/17.

2. The code for the Wanderguard System was changed by the Maintenance Director on 2/16/17 and again on 3/15/17. The Maintenance Director completed a review of the Wanderguard System including validation of properly functioning Wanderguard keypads and alarms for all facility doors on 2/16/17 and again on 3/15/17. The Maintenance Director or Administrator will continue to monitor the Wanderguard System for all facility doors daily and document on the Wanderguard Log.
The Director of Nursing and Nurse Managers completed an audit of all current residents with Wanderguards and validated placement and function of each device on 2/16/17 and again on 3/15/17.
On 2/17/17 and 3/16/17 the Director of Nursing and Nurse Managers conducted an audit of all current residents at risk for elopement to include a review of current Elopement Assessments for accuracy, validation of Wander guard placement and operation as required, validation of Physician's Orders to include checking placement of current Wanderguards every shift and function of current Wanderguards daily. These checks for placement and function will be documented by the Charge Nurse on the Medication Administration Record. Elopement care plans were reviewed and validated on 2/17/17 by the Nurse Managers.
All care plans of Residents with Wanderguard were updated on 2/17/17 and on 3/16/17 to reflect required interventions based on the review of Elopement assessments by the Nurse Managers.

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Beginning on 3/16/17, the Admissions Director will review referrals for potential admissions with identified exit seeking behaviors with the Director of Nursing and Administrator prior to offering placement to ensure proper placement. The Director of Nursing and Nurse Managers will continue to review new admissions and readmission daily during the Clinical Morning Meeting to validate accurate elopement assessments and care plans as required. The Director of Nursing and Nurse Managers will review current residents assessed at risk for elopement monthly to validate accurate assessments and care plans.
Beginning on 3/16/17 any Resident elopement will be reported immediately to the Facility's Administrator or Director of Nursing and an Incident and Accident report will be completed.

3. On 3/16/17 The Director of Nursing and Nurse Managers re-educated all current Facility Staff regarding the facility policy for Elopement. On 3/15/17 the Director of Nursing and Nurse Managers educated all current facility staff regarding changing the code on the Wanderguard System and keeping this code discrete which includes not sharing with families, visitors, vendors or residents and to report any deviations from this process to the Administrator or the Director of Nursing. On 3/15/17 the Maintenance Director changed the code for the Wanderguard System. On 3/15/17 the Administrator and the Maintenance Director implemented a process for changing the code for the Wanderguard System monthly or as needed and included this as part of the staff education.
No staff shall work after 3/15/17 before receiving this education. This education has been added to the Facility Orientation program for all new hires

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| BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT | 220 13TH AVENUE PLACE NW HICKORY, NC 28601 |

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| F 323 | Continued From page 27<br>and agency staff to be completed prior to beginning work after 3/15/17.<br><br>Immediate Jeopardy was removed on 03/16/17 at 6:35 PM when interviews with direct care staff, administrative staff and non-nursing staff confirmed they had received in-service training on the facility's Elopement Policy and not giving out the code to the front door. | F 323 | | |
| F 333 SS=E | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to administer medication per physician orders for 2 of 5 residents reviewed for medication administration (Resident's #1 and #11).<br><br>The findings included:<br><br>1. Resident #1 was admitted to the facility on 07/01/13 with diagnoses of Alzheimer's disease, anxiety and depression.<br><br>Review of the annual Minimum Data Set (MDS) dated 01/24/17 revealed Resident #1 was severely cognitively impaired and received antianxiety medications daily during the assessment period. | F 333 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F333<br><br>Criteria 1<br>The Director of Nursing completed Medication Variance Reports for ordered medications with missing signatures related to Residents #1 and #11. The Physician was notified as required. This | 4/18/17 |

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| F 333 | Continued From page 28<br>Review of the care plan dated 02/04/17 revealed Resident #1 required administration of psychoactive medication. The goal was for Resident #1 to receive the smallest dosage that continued to be effective. The interventions included: observe for medication effectiveness, observe for potential side effects and periodic reviews for potential dose reduction.<br><br>Review of the physician order's revealed the following:<br><br>10/27/14 Valium 1 milligram (mg) by mouth every night and 1 mg every 8 hours as needed for anxiety.<br><br>12/20/16 Clarification order: Valium 2 mg tablet take ½ a tablet (1 mg) by mouth every night and 1 mg (1/2 tablet) by mouth every 8 hours as needed for anxiety.<br><br>01/24/17 1. Discontinue all current Valium orders regarding gradual dose reduction attempt. 2. Valium 2mg tablet give ½ tablet (1 mg) by mouth every other night and 1 mg every 8 hours as needed for anxiety.<br><br>Review of the monthly pharmacy reviews revealed a recommendation was made on 12/22/16 to decrease valium to 1 mg every other night for anxiety. The physician's response was to accept dated 01/24/17.<br><br>Review of the Medication Administration Record (MAR) revealed the following:<br><br>The December 2016 MAR revealed Resident #1 | F 333 | was completed by 4/18/17.<br>Criteria 2<br>All residents receiving medications have the potential to be affected by this alleged deficient practice. The Director of Nursing and Nurse Managers conducted an audit of current resident□s Medication Administration Records to validate accurate transcription of Physician□s Orders and accurate documentation of administration of ordered medications from the last 30 days. This audit was completed by 4/18/17. Medication Variance Reports will be completed as opportunities are identified.<br>Criteria 3<br>The Director of Nursing or Nurse Managers will re-educate all Licensed Nurses on transcription of Physician□s orders including the process for Month End verification of accurate transcription of Physician□s Orders and the documentation of administration of medications as ordered by the physician. This education was completed by 4/18/17. The Director of Nursing or Nurse Managers will review the Order Listing report and the Medication Administration Audit report via Point Click Care 4 times per week for 12 weeks to verify accurate transcription to the Medication Administration Record and documentation of medication administration. Opportunities will be corrected daily as identified.<br><br>Criteria 4<br>The Director of Nursing will report the results of these audits and monitoring to | |

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| F 333 | Continued From page 29<br>received 1 mg Valium every evening at 6:30 PM from 12/01/16 through 12/20/16 and she began receiving a second dose of Valium 1 mg at 9:00 PM from 12/20/16 through 12/31/16.<br><br>The January 2017 MAR revealed Resident #1 received 1 mg Valium every evening at 6:30 PM and 9:00 PM from 01/01/17 through 01/10/17. She received 1 mg Valium at 6:30 PM and 10:00 PM from 01/11/17 through 01/23/17 and she received 1 mg Valium at 10:00 PM from 01/24/17 through 01/31/17 and 1 mg Valium at 7:00 PM every other night from 01/24/17 through 01/31/17.<br><br>Review of the February 2017 MAR revealed Resident #1 received Valium 1 mg every other night at 7:00 PM.<br><br>An interview conducted on 03/14/17 at 3:30 PM with the Director of Nursing (DON) revealed she was not aware of the medication error for Resident #1. She stated when an order was received it was the nurse on duty responsibility to put it in the computer and discontinue any previous order that was being replaced. The DON stated the order put in the computer on 12/20/16 should not have in been put in as a new order, she stated it was just an updated prescription for the current valium order and by putting a second order in it caused Resident #1 to receive an extra dose of valium every night. She stated the order on 01/24/17 was put in correctly but the nurse that entered the order into the computer system only discontinued one of the valium 1 mg every night order and not both orders. She stated the nurse should have gone through the MAR to make sure all previous valium orders had been cancelled. The DON further stated she and the Unit Managers reviewed the monthly MARs to | F 333 | the QAPI committee for three months, quarterly, and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. | |

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make sure they were correct and missed the medication errors in Dec. 2016 and Jan. 2017.

During an interview conducted on 03/14/17 at 4:06 PM the facility Physician stated it was his expectation that all medication orders were followed. The Physician stated the error shouldn't have happened and 2 mg of valium every night was a larger dose than what Resident #1 needed but it wasn't harmful for her.

An interview conducted with Nurse Aide #6 on 03/15/17 at 8:45 AM revealed Resident #1 was always alert in the mornings and ate breakfast in the dining room. She stated Resident #1 would take a nap around 1:00 or 1:30 PM every day and never seemed over medicated or sedated to her.

An interview conducted on 03/15/17 at 10:54 AM with the facility Pharmacy Consultant revealed she reviewed resident records once a month. She stated her reviews consisted of medication review, new and existing orders, labs, need for gradual dose reductions and information from the staff on the residents status. She stated she stopped reviewing resident MARs when the facility changed to computer MARs because it was too time consuming. The Pharmacist stated she was not aware Resident #1 had received double the dose of valium in Dec. 2016 and Jan. 2017 and she would have caught the error if she had reviewed the MAR but didn't catch it from the physician order sheet. She stated she should have reviewed the MARs for all residents.

During an interview conducted on 03/15/17 at 11:55 AM Nurse #3 stated she took the order on 01/24/17 to discontinue all valium orders and start valium 1 mg every other night and put it in the

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computer. She stated she did discontinue one of the valium 1 mg every night orders but she didn't realize there were two orders for valium 1 mg every night in the system. She stated to discontinue medication orders you looked through the MAR until you found the order you wanted to discontinue and clicked discontinue order.

An interview conducted on 03/16/17 at 4:10 PM Nurse #4 revealed it was his signature on the clarification order for valium 1 mg every night dated 12/20/16. He stated he did not remember taking the order but he must have put it in the computer as a new order and didn't discontinue the current valium order.

An interview conducted with the Administrator on 03/16/17 at 5:45 PM revealed it was her expectation for all physician orders to be followed as written and discontinued as ordered.

2. Resident #11 initially admitted to the facility on 02/09/17 and most recently readmitted to the facility on 02/28/17 and was discharged from the facility on 03/08/17. Resident #11's diagnoses included: infection of the intervertebral disc (diskitis) and kidney disease stage 2.

Review of Resident #11's most recent comprehensive minimum data set (MDS) dated 02/16/17 revealed that Resident #11 was moderately impaired for daily decision making and required only set up assistance with transfers, ambulation, dressing, eating, and toilet use. The MDS also revealed that Resident #11 received 7 days of antibiotic therapy and also received intravenous (IV) medication during the assessment period.

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Review of a facility document titled "Hospital Discharge Summary" for Resident #11 dated 02/28/17 read in part, vancomycin 1500 milligrams (mg) IV every day.

Review of medication administration record dated 03/01/17 through 03/31/17 revealed that on 03/01/17 Resident #11 received vancomycin 1500 mg IV at 9:53 AM and again at 8:48 PM.

Review of laboratory report dated 03/02/17 of a complete blood count (CBC) and a comprehensive metabolic panel (CMP) were present in the chart and been reviewed by the medical doctor (MD).

Interview with Nurse #1 on 03/16/17 at 12:42 PM revealed that she had been off for a few days and returned to work on 03/03/17 and had seen that Resident #11's vancomycin had been placed on hold. Nurse #1 stated that when she went to Resident #11's room to hang another IV medication she noted that an old bag of vancomycin was hanging but not infusing. So Nurse #1 notified UM #1 and they began to research the issue and that was when they discovered that Resident #11 had gotten 2 doses of Vancomycin 1500 mg IV on 03/01/17. Nurse #1 stated she was not sure what UM #1 did after the discovery of the error and was not sure if there were any additional orders. Nurse #1 stated that she did recall they were checking Resident #11's trough level daily until it was less than 20 and that did not take very long once he was off of the vancomycin.

Attempts to reach the MD on 03/16/17 at 6:01 PM were unsuccessful.

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Interview with the Director of Nursing (DON) on 03/16/17 at 6:15 PM revealed that she had been out on leave and had returned to work on 03/08/17 and was made aware of the medication error involving Resident #11. The DON stated that the report she received was that there was a computer glitch that evening and one order did not show up on the MAR so another order was entered and the nurse did not realize that both orders appeared on the MAR, therefore the medication was administered twice. The DON stated she had not had time to fully investigate but to her knowledge that was what had transpired. The DON further stated she expected the staff to administer the medication as ordered and in this case it was once a day and not twice a day.

Interview with the Nurse Practitioner (NP) on 03/16/17 at 6:40 PM was conducted. The NP stated she did recall Resident #11 and did recall the medication error with his vancomycin. The NP stated that the facility had "some medication errors" lately and this was one of them. The NP stated that Resident #11 was ambulatory and mobile and had a diagnoses of kidney disease stage 2. The NP stated that if Resident #11 had been more elderly and bedridden this error could have worsened his kidney function but because of his younger age and mobility it really did not affect his kidney function to her knowledge and ultimately Resident #11 was discharged home.

Interview with Nurse #4 was conducted on 03/16/17 at 6:45 PM. Nurse #4 stated that he was working on 03/01/17 and was working on entering Resident #11's orders from his most recent hospital stay and in the middle of entering and verifying the orders the computer system froze

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| F 333 | Continued From page 34<br>up. Nurse #4 stated that he had to reboot the system and when the system came back up there was no orders in the system cue (where they verified the order) so Nurse #4 stated he had re-entered the order and did not realized that the order was already in place. So Resident #11 got 2 doses of vancomycin 1500 mg IV that day, one in the morning and one in the evening.<br><br>Attempts to reach Nurse #5 on 03/16/17 at 6:55 PM were unsuccessful. Nurse #5 was the nurse who administered the extra dose of vancomycin on 03/01/17.<br><br>Interview with the Unit Manager (UM) #1 on 03/16/17 at 7:00 PM revealed that Nurse #1 had discovered the vancomycin error and reported it to her. The UM #1 stated that she had gone down and checked on Resident #11 and he was his usual self. The UM #1 stated she then called the NP and made her aware of the error and also called the pharmacy and made them aware of the error since the pharmacy was dosing Resident #11's vancomycin. The UM #1 also stated that the NP had ordered a CBC and CMP (laboratory test) and those were drawn as ordered. The UM #1 stated she also notified the Director of Nursing of the error. | F 333 | | |
| F 353 SS=E | 483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>483.35 Nursing Services<br><br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial | F 353 | | 4/18/17 |

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| F 353 | Continued From page 35<br>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).<br>[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(a) Sufficient Staff.<br>(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:<br><br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br><br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>(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.<br><br>(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.<br><br>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. | F 353 | | |

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| F 353 | Continued From page 36<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in showers and bed baths not being provided as scheduled for 3 of 4 residents reviewed (Residents #6, #7, and #8), incontinence care not being provided for 1 of 4 residents reviewed (Resident #8) and restorative care not being provided as ordered for 1 of 1 resident reviewed (Resident #6).<br><br>The findings included:<br><br>1. Cross refer to tag F-312. Based on observations, record reviews, resident and staff interviews, the facility failed to provide showers and bed baths as scheduled for 3 of 4 residents reviewed for Activities of Daily Living (ADL) (Residents #6, #7 and #8).<br><br>2. Cross refer to tag F-241. Based on record review, resident and staff interviews, the facility failed to maintain a resident's dignity by leaving him in a soiled brief for over an hour for 1 of 4 residents reviewed for dignity and respect (Resident #8).<br><br>3. Cross refer to tag F-318. Based on observation, record reviews and resident and staff interviews the facility failed to provide restorative nursing care for splint management and passive range of motion exercises for 1 out of 1 resident (Resident #6) reviewed for restorative care (Resident #6).<br><br>Interview 03/15/17 at 9:00 AM with nurse aide (NA) #1 who was also responsible for the schedule revealed that there is not enough staff | F 353 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F353<br>Criteria 1<br>On 3/17/17 the Director of Nursing validated that Residents #6 received a shower according to her preference. Resident #6 was evaluated by the Rehab Staff by 4/18/17 and a treatment plan developed to include splinting, range of motion and development of a Restorative Nursing Program for ongoing management<br>On 3/17/17 the Director of Nursing validated that Resident #7 receiving a shower according her preference.<br>On 3/16/17 the Director of Nursing validated that Resident #8 received incontinent care following an episode of bowel incontinence. On 3/17/17 the Director of Nursing validated that Resident #8 received a shower according to his preference.<br>Criteria 2<br>All residents have the potential to be affected by this alleged deficient practice.<br>Criteria 3<br>The Administrator will secure a contract for agency staffing by 3/17/17 to fill | |

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| F 353 | Continued From page 37<br>to cover the schedule. She stated that the Restorative Aides had been pulled to the hall and worked as NAs 5 out of 7 days and restorative care was not being provided to the residents. NA #1 stated that NAs on 1st shift were being asked on a regular basis to stay over to assist with 2nd shift and 3rd shift was being asked to come in early to cover 2nd shift. She stated that there were 7 full time open positions on 2nd shift for NAs. NA #1 stated that the Director of Nursing and the Administrator were aware that the schedule was short staffed.<br><br>Interview 03/15/17 at 11:35 AM with Nurse #3 revealed Administration was aware of the staffing problem and had said that they were working on getting more staff. Nurse #3 further stated that all staff had to commit to being on call 1 extra shift per week. She stated that she was on call the same day every week. Nurse #3 also stated that sometimes the on call staff had been put on the schedule which left no one to call in the event of a staff member calling out for the shift.<br><br>Interview 03/15/17 at 11:53 AM with Nurse #2 revealed the Restorative Aides were being pulled to the hall to work as NAs and residents were not receiving restorative nursing care.<br><br>Interview 03/15/17 at 2:50 PM with NA #3 revealed if they did not take any breaks or a lunch break they could get some of the work done but if they took lunch and breaks then they could not get the residents' incontinence care done.<br><br>Interview 03/16/17 at 9:08 AM with NA #4 revealed their day started with getting residents up and dressed and to the dining room for breakfast and then 1 NA from each hall had to go | F 353 | staffing needs as required.<br>The Administrator and Director of Nursing with the Interdisciplinary Team including input from Nursing Staff completed a root cause analysis regarding ongoing staffing and recruitment needs by 4/13/17. Based on this analysis and ongoing feedback from Nursing staff the following plans have been developed.<br>Beginning 4/13/17 and “All Hands on Deck” approach will be implemented to include all available facility staff to assist during meals to provide additional assistance and support to meet resident ADL needs.<br>Nursing Staff were re-educated by 4/18/17 by the Director of Nursing and Nurse Managers on the expectation of providing residents with assistance of completion of ADLs with a focus on completion of showers according to the resident’s preference and completion of incontinent care as required. Nursing Staff will immediately report to the Administrator or Director of Nursing when unable to complete ADLs for assigned residents and an alternative plan will be secured to provide additional assistance.<br>Rehab and Licensed Nurses were re-educated by the Staff Development Coordinator regarding the assessment of residents with decreased range of motion and contractures to include therapy referral for evaluation and ongoing treatment by Restorative Nursing. In the event a Restorative Aide is unavailable to complete the assigned tasks the Administrator will be notified and alternative staffing will be secured for | |

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| F 353 | Continued From page 38<br>to the dining room to assist with breakfast. She stated the NA that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that sometimes on night shift there were only 2 to 3 NAs in the building and that was not enough help to meet the needs of the residents. NA #4 stated that recently on a Sunday (could not recall date) there were residents in the dining room and there was no one in there to pass out trays and the residents had not gotten drinks as they should have with their meal. She stated that every time they turned around they were being asked to work over to cover the schedule and the staff was getting burned out. NA #4 stated that they had told the Assistant Director and the Director of Nursing but nothing had changed.<br><br>Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that she had not talked with the residents about their issues with staffing. She stated that they had used some agency NAs and tried to cover the schedule with current staff. The DON stated that managers had worked on the halls until 5:00 PM and staff were staying late and coming in early to try to cover the schedule. She stated that it was her expectation that residents get restorative care as ordered and incontinence care at least every 2-3 hours and as needed. | F 353 | completion of these interventions. The re-education was completed by 4/18/17.<br><br>The Administrator and Director of Nursing will review the Nursing schedule daily to plan ahead and prepare for staffing opportunities.<br>The Nurse Managers will randomly observe 10 residents per week, who require assistance with showers and incontinent care for 12 weeks, to validate completion of ADL assistance including showers and incontinent care. Opportunities will be corrected as identified during these audits.<br>The Rehab Director will randomly audit 5 residents weekly for 12 weeks with contractures to ensure range of motion and splinting is completed as clinically indicated. Opportunities will be corrected as identified.<br>Beginning 4/13/17 the Administrator and Director of Nursing will hold a meeting with Nursing staff weekly for 12 weeks to review and discuss facility staffing needs based on resident care needs, recruitment activity and planned hiring and orientation.<br>Criteria 4<br>The Administrator will report the results of these observations to the QAPI committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee will evaluate effectiveness | |

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| F 353 | Continued From page 39 | F 353 | of the plan and make recommendations as required. | |
| F 425 SS=E | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility's Pharmacy Consultant failed to identify a medication error for 1 of 5 residents reviewed for unnecessary drug use (Resident #1).<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 07/01/13 with diagnoses of Alzheimer's disease, anxiety and depression.<br><br>Review of the annual Minimum Data Set (MDS) dated 01/24/17 revealed Resident #1 was severely cognitively impaired and received antianxiety medications daily during the assessment period.<br><br>Review of the care plan dated 02/04/17 revealed Resident #1 required administration of | F 425 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.<br><br>F425<br><br>1. Medications for Resident #4 have been reviewed by the pharmacist by 4/18/17 to ensure the regimen is free of errors and unnecessary medications.<br><br>2. Residents receiving Psychoactive medications have to the potential to be | 4/18/17 |

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| F 425 | Continued From page 40<br>psychoactive medication. The goal was for Resident #1 to receive the smallest dosage that continued to be effective. The interventions included: observe for medication effectiveness, observe for potential side effects and periodic reviews for potential dose reduction.<br><br>Review of the physician order's revealed the following:<br><br>10/27/14 Valium 1 milligram (mg) by mouth every night and 1 mg every 8 hours as needed for anxiety.<br><br>12/20/16 Clarification order: Valium 2 mg tablet take ½ a tablet (1 mg) by mouth every night and 1 mg (1/2 tablet) by mouth every 8 hours as needed for anxiety.<br><br>01/24/17 1. Discontinue all current Valium orders regarding gradual dose reduction attempt. 2. Valium 2mg tablet give ½ tablet (1 mg) by mouth every other night and 1 mg every 8 hours as needed for anxiety.<br><br>Review of the monthly pharmacy reviews revealed a recommendation was made on 12/22/16 to decrease valium to 1 mg every other night for anxiety. The physician's response was to accept dated 01/24/17.<br><br>Review of the Medication Administration Record (MAR) revealed the following:<br><br>The December 2016 MAR revealed Resident #1 received 1 mg Valium every evening at 6:30 PM from 12/01/16 through 12/20/16 and she began receiving a second dose of Valium 1 mg at 9:00 PM from 12/20/16 through 12/31/16. | F 425 | affected by this alleged deficient practice. The Consultant Pharmacist will conduct an audit of all residents receiving Psychoactive medications to ensure their regimen is free of errors and unnecessary medications. This audit will be completed by 4/18/17.<br><br>3. The Pharmacy Manager will re-educate the Consultant Pharmacist on the proper procedures for completing a monthly drug regimen review for residents receiving Psychoactive drugs to include the identification of medication errors and the use of unnecessary medications. This education will be completed by 4/18/17. The Pharmacy Manager will conduct a monthly review of the Consultant Pharmacists drug regimen reviews for 10 residents receiving Psychoactive medications to validate accurate identification of errors or usage of unnecessary medications. Opportunities will be corrected as identified.<br><br>4. The Director of Nursing will report the results of these observations to the QAPI committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee will evaluate effectiveness of the plan and make recommendations as required. | |

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| F 425 | Continued From page 41 | F 425 | | |

The January 2017 MAR revealed Resident #1 received 1 mg Valium every evening at 6:30 PM and 9:00 PM from 01/01/17 through 01/10/17. She received 1 mg Valium at 6:30 PM and 10:00 PM from 01/11/17 through 01/23/17 and she received 1 mg Valium at 10:00 PM from 01/24/17 through 01/31/17 and 1 mg Valium at 7:00 PM every other night from 01/24/17 through 01/31/17.

Review of the February 2017 MAR revealed Resident #1 received Valium 1 mg every other night at 7:00 PM.

An interview conducted on 03/14/17 at 3:30 PM with the Director of Nursing (DON) revealed she was not aware of the medication error for Resident #1. She stated when an order was received it was the nurse on duty's responsibility to put it in the computer and discontinue any previous order that was being replaced. The DON stated the order put in the computer on 12/20/16 should not have in been put in as a new order, she stated it was just an updated prescription for the current valium order and by putting a second order in it caused Resident #1 to receive an extra dose of valium every night. The DON further stated the Pharmacy Consultant, she and the Unit Managers reviewed the monthly MARs to make sure they were correct and missed the medication errors in Dec. 2016 and Jan. 2017.

During an interview conducted on 03/14/17 at 4:06 PM the facility Physician stated it was his expectation that all medication orders were followed. The Physician stated the error shouldn't have happened and 2 mg of valium every night was a larger dose than what Resident #1 needed but it wasn't harmful for her.

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| F 425 | Continued From page 42<br><br>An interview conducted on 03/15/17 at 10:54 AM with the facility Pharmacy Consultant revealed she reviewed resident records once a month. She stated her reviews consisted of medication review, new and existing orders, labs, need for gradual dose reductions and information from the staff on the residents status. She stated she stopped reviewing resident MARs when the facility changed to computer MARs because it was too time consuming. The Pharmacist stated she was not aware Resident #1 had received double the dose of valium in Dec. 2016 and Jan. 2017 and she would have caught the error if she had reviewed the MAR but didn't catch it from the physician order sheet. She stated she should have reviewed the MARs for all residents.<br><br>An interview conducted with the Administrator on 03/16/17 at 5:45 PM revealed it was her expectation for the facility Pharmacy Consultant to review the entire resident medical record for medication errors. | F 425 | | |
| F 520 SS=J | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's | F 520 | | 4/18/17 |

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| F 520 | Continued From page 43<br>staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility's Quality Assessment and Assurance committee failed to maintain implemented procedures and monitor interventions that the committee put into place on July 8, 2016. This was for a recited deficiency originally cited in July of 2016 and subsequently recited in March of 2017 on the current complaint investigation survey. The deficiency was in the area of Accident Hazards/Supervision/Devices. The | F 520 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. | |

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| F 520 | Continued From page 44<br>continued failure during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>Immediate Jeopardy began on 02/16/17 when Resident #4 eloped from the facility without staff's knowledge that she was outside without supervision. Immediate Jeopardy was removed on 03/16/17 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D to ensure monitoring of systems put in place and completion of employee training.<br><br>The findings included:<br><br>This tag was cross referred to:<br><br>F 323: Based on observations, record review and staff interviews the facility failed to prevent 1 of 9 cognitively impaired residents, who were assessed as being at risk for elopement, from exiting the facility and leaving the facility's grounds (Resident #4).<br><br>The facility was recited for F323 for failing to prevent a resident from eloping from the facility. F323 was originally cited in July 2016 on the recertification survey for failing to provide adequate supervision to prevent a resident from falling during independent transfers from bed to wheelchair.<br><br>During an interview conducted on 03/15/17 at 5:00 PM the Administrator stated she was working in the conference room on 02/16/17 around 5:30 - 6:00 PM when Nurse #2 came in and informed her Resident #4 had eloped, | F 520 | F520<br><br>1. On 3/16/17, the Area Staff Development Coordinator conducted re-education for the Administrator on the facility□s policy and procedures for assembling a QAPI committee, collecting data and analyzing trends, and development and implementation of a plan to improve with ongoing monitoring to sustain compliance. The facility utilizes the the Plan, Do, Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee has met monthly in the past to monitor ongoing compliance with F323 Supervision to prevent Accident but will begin meeting weekly on 3/16/17 to increase monitoring with F323 Supervision to prevent Accidents with a focus on the review and monitoring of audits being conducted to correct and maintain the elopement management process and to evaluate systems for effectiveness of the facility□s overall compliance with F323 Supervision to prevent Accidents.<br>2. On 3/16/17 the Administrator, Director of Nursing and Facility Interdisciplinary Team including the Social Services Director, Admission Coordinator and Maintenance Director conducted a root cause analysis regarding facility processes for elopement prevention. Based on the results of this root cause | |

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| F 520 | Continued From page 45<br>crossed the road and was pushed back to the facility by a visitor. The Administrator stated she informed her to call the DON and complete an incident report. The Administrator stated she was not aware Resident #4 had tried to exit the building in the past. She stated the investigation conducted revealed staff would tell other staff or visitors the code to unlock the front door and Resident #4 had to know the code to exit without the alarm from her wander guard sounding. The Administrator stated Resident #4's wander guard was functioning properly because it locked the door when they tried to re-enter the building and the Maintenance Director checked it that evening and the alarm sounded when the code for the door wasn't put in first. The Administrator further stated she started a Performance Improvement Plan (PIP) on 02/17/17 for elopement for the facility Quality Assessment and Assurance (QA) Committee to begin reviewing at the meetings. She stated they will continue to monitor and audit elopement risks and supervision to prevent accidents at morning meetings and QA meetings on an ongoing basis.<br><br>The Administrator and DON were informed of Immediate Jeopardy on 03/15/17 at 6:38 PM.<br><br>On 03/16/17 at 6:35 PM, the facility provided the following Credible Allegation of Compliance:<br><br>1. On 3/16/17, the Area Staff Development Coordinator conducted re-education for the Administrator on the facility's policy and procedures for assembling a QAPI committee, collecting data and analyzing trends, and development and implementation of a plan to improve with ongoing monitoring to sustain compliance. The facility utilizes the Plan, Do, | F 520 | analysis a QA plan was developed to include re-education of all current facility staff regarding the Elopement policy and management of the Wanderguard System. A review of elopement assessments and care plans for resident at risk for elopement were reviewed and updated by the Nurse Managers. Current Residents with Wanderguards were observed for validation of placement and function of the Wanderguards. A new system was implemented to change the Wanderguard door code monthly and as needed. All current facility staff were re-educated regarding the requirements to complete an Incident Report for all elopements and to immediately report elopements to the Administrator and Director of Nursing. The Director of Nursing will implement increased supervision for the Resident involved immediately to establish safety and continue until the investigation has been completed and required interventions have been implemented. Incident Reports will be reviewed by the Interdisciplinary Team daily during the morning Stand Up meeting led by the Administrator. The Interdisciplinary team will determine acceptable interventions and ensure the care plan is revised. The Administrator will conduct the final review of the Incident report and sign off on completion. The District Director of Clinical Services will conduct a review of all Incident reports with the Administrator and Director of Nursing 3 times per week to validate completion of investigations and implementation of required | |

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| F 520 | Continued From page 46<br>Study, Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and initiation of quality improvement plans related to identified areas of opportunity. The committee has met monthly in the past to monitor ongoing compliance with F323 Supervision to prevent Accident but will begin meeting weekly on 3/16/17 to increase monitoring with F323 Supervision to prevent Accidents with a focus on the review and monitoring of audits being conducted to correct and maintain the elopement management process and to evaluate systems for effectiveness of the facility's overall compliance with F323 Supervision to prevent Accidents.<br>2. On 3/16/17 the Administrator, Director of Nursing and Facility Interdisciplinary Team including the Social Services Director, Admission Coordinator and Maintenance Director conducted a root because analysis regarding facility processes for elopement prevention. Based on the results of this root cause analysis a QA plan was developed to include re-education of all current facility staff regarding the Elopement policy and management of the Wander guard System. A review of elopement assessments and care plans for residents at risk for elopement were reviewed and updated by the Nurse Managers. Current Residents with Wander guards were observed for validation of placement and function of the Wander guards. A new system was implemented to change the Wander guard door code monthly and as needed. All current facility staff were re-educated regarding the requirements to complete an Incident Report for all elopements and to immediately report elopements to the Administrator and Director of Nursing. The Director of Nursing will implement | F 520 | interventions.<br><br>The results of this meeting and QA Plan were shared with the Facility Medical Director on 3/16/17 and he was in agreement.<br><br>3. On 3/16/17, the Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator. The Quality Assurance committee consists of:<br>" Administrator<br>" Director of Nursing<br>" Dietary Manager<br>" Rehabilitation Manager<br>" Maintenance or Environmental Representative<br>" Activities Director<br>" Social Services Director<br>" Human Resource Designee<br>" Business Office Director<br>" Resident Care Management Director<br>" Medical Director<br>" Infection Preventionist<br><br>.<br>4. New Admission and readmission will be monitored by the Director of Nursing and Nurse Managers daily during the morning clinical meeting for accurate assessments and care planned interventions as required.<br>Current Residents at risk for elopement will be monitored by the Director of Nursing and Nurse Managers weekly and as needed to review the accuracy of | |

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| F 520 | Continued From page 47<br>increased supervision for the Resident involved immediately to establish safety and continue until the investigation has been completed and required interventions have been implemented. Incident Reports will be reviewed by the Interdisciplinary Team daily during the morning Stand Up meeting led by the Administrator. The Interdisciplinary team will determine acceptable interventions and ensure the care plan is revised. The Administrator will conduct the final review of the Incident report and sign off on completion. The District Director of Clinical Services will conduct a review of all Incident reports with the Administrator and Director of Nursing 3 times per week to validate completion of investigations and implementation of required interventions.<br><br>The results of this meeting and QA Plan were shared with the Facility Medical Director on 3/16/17 and he was in agreement.<br><br>3. On 3/16/17, the Administrator and the Quality Assurance Committee were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator.<br>The Quality Assurance committee consists of:<br>Administrator<br>Director of Nursing<br>Dietary Manager<br>Rehabilitation Manager<br>Maintenance or Environmental Representative<br>Activities Director<br>Social Services Director<br>Human Resource Designee<br>Business Office Director<br>Resident Care Management Director<br>Medical Director | F 520 | assessments and care plans for ongoing interventions.<br>The Maintenance Director or Administrator will continue to monitor the Wanderguard System for all facility doors daily and document on the Wanderguard Log<br>The Administrator and the Director of Nursing will present the results of this monitoring of the Elopement Process and Wanderguard System to the Quality Assurance & Performance Improvement committee weekly for 12 weeks and then monthly thereafter. The next Quality Assurance & Performance Improvement meetings will be conducted weekly for 12 weeks, then monthly with oversight by District Director of Clinical Services for three months . | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345080 | A. BUILDING _____ B. WING _____ | C 03/16/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT | 220 13TH AVENUE PLACE NW HICKORY, NC 28601 |

| (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 520 | Continued From page 48<br>Infection Preventionist<br><br>4. New Admission and readmission will be monitored by the Director of Nursing and Nurse Managers daily during the morning clinical meeting for accurate assessments and care planned interventions as required.<br>Current Residents at risk for elopement will be monitored by the Director of Nursing and Nurse Managers weekly and as needed to review the accuracy of assessments and care plans for ongoing interventions.<br>The Maintenance Director or Administrator will continue to monitor the Wander guard System for all facility doors daily and document on the Wander guard Log.<br><br>The Administrator and the Director of Nursing will present the results of this monitoring of the Elopement Process and Wander guard System to the Quality Assurance & Performance Improvement committee weekly for 12 weeks and then monthly thereafter. The next Quality Assurance & Performance Improvement meetings will be conducted weekly for 12 weeks, then monthly with oversight by District Director of Clinical Services for three months.<br><br>Immediate Jeopardy was removed on 03/16/17 at 6:35 PM when interviews with direct care staff, administrative staff and non-nursing staff confirmed they had received in-service training on the facility's Elopement Policy and not giving out the code to the front door. | F 520 | | |