| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345129 | A. BUILDING _____ B. WING _____ | 04/13/2017 |

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|---|---|
| AUTUMN CARE OF MOCKSVILLE | 1007 HOWARD STREET MOCKSVILLE, NC 27028 |

| (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 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 observations, record review, and staff interviews the facility failed to maintain the dignity of 1 of 3 residents by allowing the resident to remain in visibly soiled pants with a hole in them for 34 minutes (Resident #103).<br><br>The findings included:<br><br>Resident #103 was admitted to the facility on 12/22/16 with diagnoses that included apraxia of speech, severe aphasia, cerebral infarction, subarachnoid hemorrhage, and hemiplegia.<br><br>Review of a care plan created 01/13/17 titled "Activities of Daily Living (ADLs)" stated Resident #103 had self-care deficit related to residual effects from cerebral vascular accident including right hemiparesis, aphasia, and dysphagia. The goal of the stated care plan was Resident #103 would have ADLs met through next review. The interventions of the care plan included: Provide incontinent care as necessary and report to nursing when resident declined care.<br><br>Review of most recent quarterly minimum data set (MDS) dated 02/23/17 revealed that Resident #103 was cognitively intact, had unclear speech, and was sometimes understood. The MDS also revealed that Resident #103 required extensive | F 241 | This plan of constitutes our written plan of compliance for deficiencies cited; however, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.<br><br>Resident Affected: Resident was cleaned of incontinence and changed at the time of notification by the CNA and nurse.<br><br>Other residents with the potential to be affected: Social Services and Administrator interviewed on 5/8/2017 all alert and oriented residents related to being treated with dignity and respect. Identified areas were corrected at the time (No other areas of concern were identified).<br>The social worker observed all non interviewable residents to ensure that they were properly attired and no dignity issues were observed.<br><br>Systemic Change: Staff members were inserviced by the Director of Nursing on | 5/8/17 |

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

Electronically Signed | 05/08/2017

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| F 241 | Continued From page 1<br>assistance of 2 staff members for transfers and toileting and was always incontinent of bowel and bladder. No behaviors were identified on the MDS.<br><br>Review of Resident #103's medical record from 04/10/17 through 04/11/17 revealed no refusal of care.<br><br>On 04/11/17 at 9:02 AM an observation and interview with Resident #103 was made. Resident #103 was sitting in his wheelchair in the doorway of his room he was dressed in a light colored shirt and brown sweat pants. The sweat pants were visibly wet between his legs and there was a hole approximately the size of quarter in the left upper pant leg. Resident #103 requested that his call light be turned on and his pants to be changed due to him being wet and having a hole in them. The call light was turned on at 9:02 AM, while resident waited in his room with the door closed. Resident #103 indicated that he did not like being wet and did not like having pants with a hole in them, it "made him feel bad" and Resident #103 started to cry. After waiting for staff to answer Resident #103's call light for 30 minutes the housekeeper knocked on door and apologized for interrupting us. Resident #103 indicated to her that he needed some help. The housekeeper then shut the door. Resident #103 continued to cry and after additional 10 minutes Nurse #3 was summoned for help. Nurse #3 stated the call light was not working properly and she was not aware that Resident #103 needed assistance.<br><br>On 04/11/17 at 9:36 AM Nursing Assistant (NA) #1 entered the room to provide incontinent care to Resident #103. Resident #103 asked the surveyor to step out into the hallway during the | F 241 | Dignity of residents with completion of May 8, 2017.<br>Three residents will be questioned or observed related to dignity by Social Worker weekly for three weeks and then monthly for three months. The Administrator or Director of Nursing will audit these questionnaires/observations related to dignity. If any area of concern are identified, this will be addressed at that time. Continued areas of concern will be addressed in monthly QA meeting for further action plan. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved.<br><br>Quality Assurance/Monitoring: Nurses check resident #103 three times a shift to ensure cleanliness and proper attire. These audits will be performed by the Director of Nursing. | |

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care. NA #1 indicated that she was not aware that Resident #103 needed assistance because his call light was not working. NA #1 stated she had just finished breakfast and had started her morning round and was actually in the room next door when Nurse #3 notified her that Resident #103 needed to be changed. NA #1 indicated that Resident #103 had been up since before her shift and he would have been next on her round for incontinent care. NA #1 stated she had not changed Resident #103 since coming on shift but rounded on her residents immediately after breakfast and was not aware that Resident #103 was wet or needed assistance prior to being told by Nurse #3.

On 04/12/16 at 4:12 PM an interview with Director of Nursing (DON) was conducted. The DON stated that Resident #103 was a "different type of resident, he refused care a lot, and he refused for the staff to touch him all night long." The DON stated that Resident #103 got very angry and demanded to be up at 6:00 AM. The DON stated that on 04/11/17 she had noticed the hole in his pants and the NA had attempted to redress him but he refused. The DON stated that if she would have seen Resident #103's call light on 04/11/17 she would have responded but it was not on so she or her staff did not know that Resident #103 required assistance, but she did expect her staff to treat residents with respect and dignity.

On 04/13/17 at 8:55 AM an interview with NA #2 was conducted. NA #2 stated she routinely cared for Resident #103 and at times he would cuss at staff because the staff had trouble understanding what he was saying. NA #2 stated that Resident #103 got up on 3rd shift and was up when she arrived for work that morning. NA #2 stated she

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| F 241 | Continued From page 3<br>was getting ready to take Resident #103 to the restroom using the lift and 2 person assist. NA #2 stated Resident #103 was incontinent of bowel and bladder and did not know when he voided or defecated. NA #2 stated she has had no issues with Resident #103 as long as he was calm she was able to understand him.<br><br>On 04/13/17 at 9:21 AM an interview with Nurse #3 was conducted. Nurse #3 stated that Resident #103 was very demanding and had no patience at all. Nurse #3 stated that most of the time the staff was able to figure out what Resident #103's needs were, but it was a lot harder to understand him if he was upset. Nurse #3 stated when Resident #103 wanted something, he wanted it right then even if the staff was assisting other residents. Nurse #3 stated that they usually asked him to calm down and told him they would be right with him and he was usually ok with that and the staff usually did not have any problems with Resident #103 on her shift. Nurse #3 stated that Resident #103 gets up between 5:30 AM and 6:00 AM in the morning and was up when she arrived at work. Nurse #3 stated that Resident #103 did not refuse care and instead demanded care. Nurse #3 stated that if a resident refused care the NAs documented in their electronic kiosk and she would document in the electronic medical record. | F 241 | | |
| F 253 SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by: | F 253 | | 5/11/17 |

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| F 253 | Continued From page 4<br>Based on observations and staff interviews the facility failed to repair resident room and bathroom doors with broken and splintered laminate and wood in 8 of 40 rooms on the 200 and 300 halls (resident room #206, #210, #216, #300, #303, #304, #308 and #309), failed to repair smoke prevention doors with broken and splintered laminate and wood on the 200 hall, failed to repair a fire door with broken and splintered laminate and wood at the entrance of the 200 hall, failed to repair the shower/bath door on the 400 hall with broken and splintered laminate and wood on the lower edges of the door and failed to remove brown stains from around the base of toilets and bathroom floors in 3 of 13 rooms on the 300 hall (resident room #304, #308 and #309).<br><br>Findings included:<br><br>1. a. Observations on 04/10/17 at 11:57 AM in the bathroom of resident room #206 revealed there was a long sliver of a splinter approximately 1 and ½ - 2 inches in length with a sharp point on the lower edge of the bathroom door and there was broken and splintered laminate and wood on the edges of the resident's room door.<br>Observations on 04/11/17 at 9:27 AM in the bathroom of resident room #206 revealed there was a long sliver of a splinter approximately 1 and ½ - 2 inches in length with a sharp point on the lower edge of the bathroom door and there was broken and splintered laminate and wood on the edges of the resident's room door.<br>Observations on 04/12/17 at 2:28 PM in the bathroom of resident room #206 revealed there was a long sliver of a splinter approximately 1 and ½ - 2 inches in length with a sharp point on the lower edge of the bathroom door and there was | F 253 | Residents affected: The doors in Rooms 206, 210, 216, 300, 303, 304, 308, and 309 as well as the smoke prevention doors on 200 hall, the entrance to 200 hall, and the shower bath door on 400 hall are repaired by 5/11/2017 by the Maintenance Director.<br><br>The bathroom floors in Rooms 304, 308, and 309 have been repaired by 5/11/2017.<br><br>Residents with the potential to be affected: All doors were checked for broken/splintered laminate and wood and have been sanded by 5/11/2017.<br><br>All resident bathroom floors were audited for need of repair/replacement of tile. A plan is in place to repair five bathrooms weekly until all bathrooms have been repaired.<br><br>Systemic changes: Staff has been inserviced on the proper usage of updated Work Order forms by the Administrator. The Maintenance Director will check all doors and bathroom floors throughout the facility two times per month to ensure that all doors and floors are in good repair. Any area identified will be corrected at that time.<br><br>QA and Monitoring: The Administrator will audit five facility doors and floors per week for three weeks and then five doors and floors monthly. Any area identified will be corrected at that time. Random monitoring will occur and will be reported | |

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| F 253 | Continued From page 5<br>broken and splintered laminate and wood on the edges of the resident's room door.<br><br>b. Observations on 04/10/17 at 11:46 AM in the bathroom of resident room #210 revealed broken and splintered laminate and wood on the lower edges of the bathroom door.<br>Observations on 04/11/17 at 10:58 AM in the bathroom of resident room #210 revealed broken and splintered laminate and wood on the lower edges of the bathroom door.<br>Observations on 04/12/17 at 1:54 PM in the bathroom of resident room #210 revealed broken and splintered laminate and wood on the lower edges of the bathroom door.<br><br>c. Observations on 04/10/17 at 11:47 AM revealed the door to resident room #216 had broken and splintered laminate and wood on the lower edges of the door.<br>Observations on 04/11/17 at 10:59 AM revealed the door to resident room #216 had broken and splintered laminate and wood on the lower edges of the door.<br>Observations on 04/12/17 at 1:57 PM revealed the door to resident room #216 had broken and splintered laminate and wood on the lower edges of the door.<br><br>d. Observations on 04/11/17 at 10:53 AM revealed the door to resident room #300 had broken and splintered laminate on the lower edges of the door.<br>Observations on 04/12/17 at 2:04 PM revealed the door to resident room #300 had broken and splintered laminate on the lower edges of the door.<br>Observations on 04/13/17 at 11:09 AM revealed the door to resident room #300 had broken and | F 253 | to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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splintered laminate on the lower edges of the door.

e. Observations on 04/10/17 at 11:39 AM revealed the door to resident room #303 had broken and splintered laminate on the lower edges of the door and broken and splintered laminate and wood on the lower edges of the bathroom door.
Observations on 04/11/17 at 10:54 AM revealed the door to resident room #303 had broken and splintered laminate on the lower edges of the door and broken and splintered laminate and wood on the lower edges of the bathroom door.
Observations on 04/12/17 at 2:09 PM revealed the door to resident room #303 had broken and splintered laminate on the lower edges of the door and broken and splintered laminate and wood on the lower edges of the bathroom door.

f. Observations on 04/10/17 at 11:40 AM revealed the door to resident room #304 had broken and splintered laminate on the lower edges of the door.
Observations on 04/11/17 at 10:55 AM revealed the door to resident room #304 had broken and splintered laminate on the lower edges of the door.
Observations on 04/12/17 at 2:12 PM revealed the door to resident room #304 had broken and splintered laminate on the lower edges of the door.

g. Observations on 04/10/17 at 11:19 AM revealed the door to resident room #308 had broken and splintered laminate on the lower edges of the door and the bathroom door had broken and splintered laminate and wood on the lower edges of the door.

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Observations on 04/11/17 at 10:57 AM revealed the door to resident room #308 had broken and splintered laminate on the lower edges of the door and the bathroom door had broken and splintered laminate and wood on the lower edges of the door.
Observations on 04/12/17 at 2:17 PM revealed the door to resident room #308 had broken and splintered laminate on the lower edges of the door and the bathroom door had broken and splintered laminate and wood on the lower edges of the door.

h. Observations on 04/10/17 at 11:44 AM in resident room #309 revealed inside the bathroom door on the right lower corner there was a large area of broken and splintered laminate on the door.
Observations on 04/11/17 at 10:59 AM in resident room #309 revealed inside the bathroom door on the right lower corner there was a large area of broken and splintered laminate on the door.
Observations on 04/12/17 at 2:20 PM in resident room #309 revealed inside the bathroom door on the right lower corner there was a large area of broken and splintered laminate on the door.

2. Observations on 04/10/17 at 12:05 PM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the lower edges of the doors.
Observations on 04/11/17 at 10:02 AM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the lower edges of the doors.
Observations on 04/12/17 at 2:01 PM revealed the smoke prevention doors on the 200 hall had broken and splintered laminate on the lower edges of the doors.

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3. Observations on 04/10/17 at 12:07 PM revealed the fire door on the right side of the entrance to the 200 hall had broken and splintered laminate on the lower edges of the door.
Observations on 04/11/17 at 2:26 PM revealed the fire door on the right side of the entrance to the 200 hall had broken and splintered laminate on the lower edges of the door.
Observations on 04/12/17 at 2:33 PM revealed the fire door on the right side of the entrance to the 200 hall had broken and splintered laminate on the lower edges of the door.

4. Observations on 04/10/17 at 12:15 PM revealed the shower/bath door on the 400 hall had broken and splintered laminate on the lower edges of the door with deep gouges in the wood on the edges of the door.
Observations on 04/11/17 at 10:22 AM revealed the shower/bath door on the 400 hall had broken and splintered laminate on the lower edges of the door with deep gouges in the wood on the edges of the door.
Observations on 04/12/17 at 2:05 PM revealed the shower/bath door on the 400 hall had broken and splintered laminate on the lower edges of the door with deep gouges in the wood on the edges of the door.

5. a. Observations on 04/10/17 at 11:41 AM in the bathroom of resident room #304 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.
Observations on 04/11/17 at 10:56 AM in the bathroom of resident room #304 revealed there were dark brown stains in the grout around the

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base of the toilet and on the floor around the base of the toilet.
Observations on 04/12/17 at 2:19 PM in the bathroom of resident room #304 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.

b. Observations on 04/10/17 at 11:19 AM in the bathroom of resident room #308 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.
Observations on 04/11/17 at 10:57 AM in the bathroom of resident room #308 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.
Observations on 04/12/17 at 2:17 PM in the bathroom of resident room #308 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.

c. Observations on 04/10/17 at 11:44 AM in the bathroom of resident room #309 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.
Observations on 04/11/17 at 10:59 AM in the bathroom of resident room #309 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.
Observations on 04/12/17 at 2:20 PM in the bathroom of resident room #309 revealed there were dark brown stains in the grout around the base of the toilet and on the floor around the base of the toilet.

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During an Interview on 04/13/17 at 11:24 AM with the Maintenance Director he explained he had an assistant who helped him to complete repairs in the facility He explained they did not have any major renovations planned but had started repairing sheet rock damage to walls in resident rooms last week. He stated repairs were an ongoing process and they utilized a work order system. He explained the work order forms were kept in a file holder on his door and anyone could fill out a work order and leave it in the holder and they would do the repair and document when the repair was completed. He stated anyone including staff, residents and visitors could fill out work orders and he tracked them to ensure repairs were completed. He further stated he expected for work orders to be completed for anything that needed to be repaired. He explained he reviewed the work order system with all new employees during orientation and he wanted to know who had filled out the work order, what needed to be repaired, when damage was noticed and where it was located. He stated he and his assistant made rounds every day and they had a list of routine things they checked every day such as water temperatures or whether the alarms worked on exit doors.

During an environmental tour with the Maintenance Director and Administrator on 04/13/17 at 11:34 AM the Maintenance Director confirmed no one had completed work orders or reported damage to resident doors, bathroom doors, smoke prevention doors, fire doors or shower/bath doors. He stated the grout around toilets and floor tiles needed to be replaced and he would expect for housekeeping staff to report stains or damage around toilets when they

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| F 253 | Continued From page 11<br>mopped and cleaned bathrooms.<br><br>During an interview on 04/13/17 at 11:47 AM with the Administrator he stated it was his expectation to maintain a safe, comfortable environment. He also stated it was his expectation for staff to use the work order system to communicate repairs that needed to be made to maintenance. | F 253 | | |
| F 281 SS=E | 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews the facility staff failed to dispense medication directly into a medicine cup from unit dose packages and bottles for 3 of 5 residents observed during medication pass (Resident #19, Resident #55, and Resident #60).<br><br>The findings included:<br><br>Review of a facility document titled "General Dose Preparation and Medication Administration" dated 12/01/07 read in part, facility staff should not touch the medication when opening a bottle or unit dose package.<br><br>1. Resident #19 was re-admitted to the facility on 10/20/16 with diagnoses that included hypopituitarism (a decrease in the secretion of | F 281 | Resident Affected: On 4/12/2017 when the Director of Nursing was notified by surveyor of concerns from the previous day's med pass, Nurse #2 was suspended and later terminated.<br><br>Other residents with the potential to be affected: All staff nurses received education on the Five Rights of Med Passes by the RN Nurse Supervisor with completion of 5/8/2017. All nurses were checked off on the medication administration skills checklist by 5/11/2017 by the Director of Nursing and RN Supervisors.<br><br>Systemic Changes: Medication administration education and observation | 5/11/17 |

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| F 281 | Continued From page 12<br>the hormones produced by the pituitary gland).<br><br>Review of the most recent quarterly minimum data set (MDS) dated 01/22/17 revealed that Resident #19 had modified independence with daily decision making and had long/short term memory problems. The MDS revealed that Resident #19 required one person assist with activities of daily living.<br><br>On 04/11/17 at 4:24 PM a continuous observation of Nurse #2 preparing Resident #19's medication was made. Nurse #2 was observed to punch 2 tablets out of a unit dose card into her ungloved left hand and then place the tablets into a medication cup sitting on top of the medication cart. Nurse #2 was then observed to open a bottle of tablets and pour 1 tablet directly into her ungloved left hand and then placed that tablet into the medication cup sitting on top of the medication cart. Nurse #2 then locked her medication cart and took the medicine cup with the tablets in them and entered Resident #19's room and administered the tablets to the resident. Nurse #2 returned to the medication cart and used the mouse to electronically sign the record of the administration. Nurse #2 did not wash her hands or use hand sanitizer before or after the administration of the tablets.<br><br>An interview with Nurse #2 was conducted on 04/11/17 at 4:39 PM and revealed that she had worked at the facility for 8 months. Nurse #2 stated that she "normally pops the pills directly into her hand, I only use gloves when doing eye drops or checking blood sugars." Nurse #2 stated she was scared she would lose the pill by directly popping the pill from the unit dose package or bottle to the medicine cup and it was easier for | F 281 | by Director of Nursing or Administrative Nursing Staff will occur quarterly. Each nurse will be observed to ensure that they are following the five rights of medication administration. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved.<br><br>Quality Assurance/Monitoring: The Administrator will ensure that the medication administration education and observations are completed quarterly for licensed nurses. | |

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her to pop the pill into her hand. Nurse #2 further stated that the staff was expected to wash hands or use hand sanitizer between each resident. Nurse #2 stated "she got in the zone and ran in/out rooms and just forgets to do it. " Nurse #2 then stated that "that she should probably being washing or using hand sanitizer between patients but I am just handing them a cup and I forget."

On 04/12/17 at 4:19 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that the actions of Nurse #2 were "totally inappropriate." The DON stated that the nursing staff was expected to place the pills directly into the medication cup and not in their hands. The DON further stated that Nurse #2 should have gloves on if she was popping the pills directly into her hand and then she should remove the gloves and wash her hands. The DON further stated that if the staff hands were not visibly soiled then they should be using hand sanitizer between each resident.

2. Resident #55 was readmitted to the facility on 08/15/16 with diagnoses that included chronic obstructive pulmonary disease.

Review of the most recent minimum data set (MDS) dated 01/09/17 revealed that Resident #55 was cognitively intact and required one person assistance with activities of daily living.

On 04/11/17 at 4:13 PM a continuous observation of Nurse #2 preparing Resident #55's medication was made. Nurse #2 was observed to punch 2 tablets out of a unit dose card into her ungloved left hand and then place the tablets into a medication cup sitting on top of the medication cart. Nurse #2 was then observed to open a

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bottle of tablets and pour 2 tablets directly into her ungloved left hand and then placed the tablets into the medication cup sitting on top of the medication cart. Nurse #2 then locked her medication cart and took the medicine cup with the tablets in them and entered Resident #55's room and administered the tablets to the resident. Nurse #2 returned to the medication cart and used the mouse to electronically sign the record of the administration. Nurse #2 did not wash her hands or use hand sanitizer before or after the administration of the tablets.

An interview with Nurse #2 was conducted on 04/11/17 at 4:39 PM and revealed that she had worked at the facility for 8 months. Nurse #2 stated that she "normally pops the pills directly into her hand, I only use gloves when doing eye drops or checking blood sugars." Nurse #2 stated she was scared she would lose the pill by directly popping the pill from the unit dose package or bottle to the medicine cup and it was easier for her to pop the pill into her hand. Nurse #2 further stated that the staff was expected to wash hands or use hand sanitizer between each resident. Nurse #2 stated "she got in the zone and ran in/out rooms and just forgets to do it. " Nurse #2 then stated that "that she should probably being washing or using hand sanitizer between patients but I am just handing them a cup and I forget."

On 04/12/17 at 4:19 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that the actions of Nurse #2 were "totally inappropriate." The DON stated that the nursing staff was expected to place the pills directly into the medication cup and not in their hands. The DON further stated that Nurse #2 should have gloves on if she was popping the

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pills directly into her hand and then she should remove the gloves and wash her hands. The DON further stated that if the staff hands were not visibly soiled then they should be using hand sanitizer between each resident.

3. Resident #60 was admitted to the facility on 09/16/13 with diagnoses that included hypertension, diabetes mellitus, chronic embolism, anxiety, and depression.

Review of the Resident #60's most recent quarterly Minimum data set (MDS) dated 02/26/17 revealed that Resident #60 was cognitively intact and required extensive assistance of 2 staff members for bed mobility and transfers.

On 04/11/17 at 4:34 PM a continuous observation of Nurse #2 preparing Resident #60's medication was made. Nurse #2 was observed to punch 4 tablets out of a unit dose card into her ungloved left hand and then place the tablets into a medication cup sitting on top of the medication cart. Nurse #2 was then observed to open a bottle of tablets and pour 2 tablets directly into her ungloved left hand and then placed the tablets into the medication cup sitting on top of the medication cart. Nurse #2 then locked her medication cart and took the medicine cup with the tablets in them and entered Resident #60's room and administered the tablets to the resident. Nurse #2 returned to the medication cart and used the mouse to electronically sign the record of the administration. Nurse #2 did not wash her hands or use hand sanitizer before or after the administration of the tablets.

An interview with Nurse #2 was conducted on

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| F 281 | Continued From page 16<br>04/11/17 at 4:39 PM and revealed that she had worked at the facility for 8 months. Nurse #2 stated that she "normally pops the pills directly into her hand, I only use gloves when doing eye drops or checking blood sugars." Nurse #2 stated she was scared she would lose the pill by directly popping the pill from the unit dose package or bottle to the medicine cup and it was easier for her to pop the pill into her hand. Nurse #2 further stated that the staff was expected to wash hands or use hand sanitizer between each resident. Nurse #2 stated "she got in the zone and ran in/out rooms and just forgets to do it. " Nurse #2 then stated that "that she should probably being washing or using hand sanitizer between patients but I am just handing them a cup and I forget."<br><br>On 04/12/17 at 4:19 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that the actions of Nurse #2 were "totally inappropriate." The DON stated that the nursing staff was expected to place the pills directly into the medication cup and not in their hands. The DON further stated that Nurse #2 should have gloves on if she was popping the pills directly into her hand and then she should remove the gloves and wash her hands. The DON further stated that if the staff hands were not visibly soiled then they should be using hand sanitizer between each resident. | F 281 | | |
| 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, as outlined by the comprehensive care plan, must- | F 282 | | 5/8/17 |

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| F 282 | Continued From page 17<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 observations, record reviews, and staff interviews the facility failed to implement care plan interventions by not applying a concave mattress as instructed by the care plan for 1 of 3 residents (Resident #7).<br><br>The findings included:<br><br>Resident #7 was admitted to the facility on 01/25/17 with diagnoses that included repeated falls, dementia, Alzheimer's disease, and others.<br><br>Review of a care plan that was initiated on 01/26/17 and revised on 03/08/17 read in part, Resident #7 was at risk for falls related to decreased mobility, weakness, history of falls, and short/long term memory deficits. The goal of the stated care plan was Resident #7 would have no preventable injury from falls through the next review. Interventions included concave mattress to bed.<br><br>Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/08/17 revealed that Resident #7 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, and toileting. The MDS further revealed that Resident #7 had a history of falls prior to admission and had no falls since admission.<br><br>Review of Resident #7's visual/bedside kardex listed the device that Resident #7 had in place as concave mattress to bed. | F 282 | Resident affected: The resident affected was assessed for continued need of concave mattress and the care plan was updated to reflect that the concave mattress was not needed.<br><br>Other residents with potential to be affected: All residents on concave mattresses were reviewed by administrative nurses to ensure that appropriate care plan interventions were in place.<br><br>Systemic Changes: Staff members were educated to review the Kardex to ensure resident interventions were in place per plan of care.<br><br>Quality Assurance/Monitoring: Administrative nurses will review residents requiring raised perimeter mattresses weekly for three weeks and then monthly for three months to ensure mattresses are in place and that care plans are in place. Any areas identified will be corrected at that time. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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Observation of Resident #7's bed on 04/10/17 revealed there was a standard mattress in place, no concave mattress was noted.

Observation of Resident #7's bed on 04/11/17 at 1:31 PM revealed there was a standard mattress in place, no concave mattress was noted.

Observation of Resident #7's bed on 04/12/17 at 8:55 AM revealed there was a standard mattress in place, no concave mattress was noted.

On 04/12/17 at 2:06 PM an interview with the MDS Nurse was conducted. The MDS nurse stated that the concave mattress was added to the care plan on 02/19/17 after Resident #7 had a fall on 01/28/17. The MDS nurse stated that after Resident #7 fell on 01/28/17 she had went to the emergency room and returned on 02/01/17 and we discussed it and updated the care plan on 02/19/17 which was adding the concave mattress. The MDS nurse stated that when they have devices like the concave mattress that were needed they fill out a work order during the morning meeting and give it to the Maintenance Director (MD) so the devices could be added.

Observation of Resident #7's bed on 04/12/17 at 2:25 PM revealed there was a standard mattress in place, no concave mattress was noted.

Observation of Resident #7's bed on 04/12/17 at 2:30 PM made with the MD confirmed that Resident #7's mattress was a standard mattress and not a concave mattress.

Interview with the MD on 04/12/17 at 2:35 PM revealed that during the morning meeting if the

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team needed anything repaired or devices added or removed they would fill out a work order and either he or his assistant would take care of it. The MD reviewed his work orders for the last 4 months and could not locate a work order requesting a concave mattress for Resident #7. The MD did find a work order dated 03/08/17 requesting Resident #7 be moved from Pine Hall to Oak Hall and he had completed that as requested. The MD stated that he did not keep a list of resident with concave mattress because they did not use them very often.

Interview with Nurse #4 on 04/12/17 at 3:23 PM revealed that she took care of Resident #7 at times. Nurse #4 stated she was taking are of Resident #7 on 01/28/17 when she fell and was sent to the emergency room. Nurse #4 stated that Resident #7 was sitting up in her wheelchair and tried to get up to help another resident and fell. Since no one saw her fall our protocol was to send the resident to the emergency room for evaluation. Nurse #4 stated that Resident #7 had no injury and returned to the facility. Nurse #4 also stated that the kardex system was what the nursing assistants (NA) use to know what devices the resident required and how much assistance each resident required. Nurse #4 stated that Resident #7 had a concave mattress when she was on Pine hall but had not had one since moving to Oak hall.

Interview with the Director of Nursing (DON) on 04/12/17 at 3:35 PM revealed that the kardex system was electronic and the NAs are to review each kardex each day for any changes or updates. The DON does not recall the concave mattress that was implemented for Resident #7 and wonders if it was intended for another

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| F 282 | Continued From page 20<br>resident. The DON stated that she does expect the staff to follow the care plan and if the care plan stated concave mattress then Resident #7 should have had a concave mattress.<br><br>Interview with NA #2 on 04/13/17 revealed that she was taking care of Resident #7 for the first time and to her knowledge Resident #7 did not have a concave mattress. NA #2 stated that their fall interventions where listed in the computer and they can review them if they need to. NA #2 stated she had not reviewed Resident #7's kardex yet but if she needed to she could. | F 282 | | |
| F 323 SS=D | 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. | F 323 | | 5/8/17 |

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| F 323 | Continued From page 21<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to have a side rail securely attached to the bed frame for 1 of 40 (resident #14)<br><br>The findings included:<br><br>Resident #14 was admitted to the facility 03/12/09 with diagnoses of major depressive disorder, chronic pain, tremor, muscle weakness, multiple sclerosis and dysphagia. Review of resident #14's most recent comprehensive Annual MDS assessment dated 03/17/17 revealed resident #14 moderately impaired for daily decision making. The MDS also revealed Resident #14 needed a one person, physical assist with bed mobility, locomotion on/off unit, dressing, toileting, personal hygiene and bathing.<br><br>On 04/10/17 at 10:55 AM an observation was made that resident's right side rail to be very loose, with significant movement from where the rail would be tight against the bed to where it was resting. Leaving a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. The left side rail was noted to be in good operating order, tight against the mattress when raised with little to no movement.<br><br>On 04/11/17 10:39 AM Observation of resident #14 in his room, in bed, reading a magazine. | F 323 | Resident Affected: The Director of Maintenance tightened the side rail on 4/12/2017.<br><br>Residents with the potential to be affected: An audit of 100% of the beds with side rails was completed on 4/12/2017 and no other areas were identified.<br><br>System Changes: Staff education by Administrator and Director of Nursing related to completion of work orders and timely notification of areas needing to be addressed was completed by 5/8/2017.<br><br>Quality Assurance/Monitoring:<br>Residents with side rails on beds will be audited weekly for three weeks and then monthly times three months to ensure side rails are attached and functioning properly. The Administrator will review audits of these side rail reviews. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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| F 323 | Continued From page 22 | F 323 | | |

Observation of resident's right side rail still very loose. It continued to leave a significant gap between the mattress and the side rail. The side rail was attached to the bed frame but when moved side to side, the side rail was not tight against the bed frame but rather moved outward, away from the mattress. Observation of the bolts that held the rail to the bed frame revealed the nuts to be loose which caused the right side rail to remain loose.

04/12/17 8:36 AM observation of resident's side rail still very loose on right side.

04/11/17 3:43 PM an interview with resident #14. He stated that he used the side rails to assist him in shifting and turning. He further stated he had noticed that the rails are loose but was unsure if he had reported them.

4/12/17 4:06 PM interview with Maintenance Director revealed resident's side rails were checked weekly. He stated that he and his helper physically checked "every bed" in the facility weekly.

04/12/17 4:47 PM during a follow up interview with Maintenance Director he stated he checked bed rails every Monday. On a walkthrough the Maintenance director was asked to measure the gap provided due to resident #14's loose side rail on the right side of the bed. He measured resident #14's side rail movement and reported that the total movement from where the rail should be, to where the rail was as "2 3/4 inches". He stated that he did not care for the type of side rail that was on resident #14's bed as they were bolted to the bed and was only able to be adjusted or tightened where the side rail and the

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| F 323 | Continued From page 23<br>bed frame met. He stated that he did not check the beds with this type of bed rail as often as the side rails that had a knob on the rail to allow it to be tightened up easily. He further stated he was unable to recall the last time resident #14's side rail was last inspected.<br><br>04/13/17 1:35 PM interview with Administrator revealed the Maintenance Director checked side rails weekly. He stated that since staff is in and out of rooms, they should be monitoring side rails and adjust as needed. He continued, he expected staff to report to maintenance for loose rails that need to be tightened to bed frame if staff were unable to tighten themselves. | F 323 | | |
| F 329 SS=E | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. | F 329 | | 5/8/17 |

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| F 329 | Continued From page 24<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to follow a physician order and discontinue a medication after 10 days as prescribed for 1 of 5 residents sampled for unnecessary medications (Resident #7).<br><br>The findings included:<br><br>Resident #7 was admitted to the facility on 01/25/17 with diagnoses that included anxiety, dementia, and depression.<br><br>Review of a physician order for Resident #7 dated 02/01/17 read Lorazepam (Ativan) 0.5 milligrams (mg) by mouth every 8 hours as needed for anxiety for up to 10 days. The order was put into the electronic medical record by Nurse #1.<br><br>Review of the medication administration record (MAR) dated 02/01/17 through 02/28/17 revealed | F 329 | Resident Affected: The nurse practitioner was notified on 4/12/2017 by a licensed nurse and order was received to continue Lorazepam 0.5 mg every 8 hours with no stop date.<br><br>Residents with the potential to be affected: Physician orders for all new admissions from 4/14/2017 were reviewed for accuracy. No other areas were identified.<br><br>Systemic Changes: The first nurse enters orders, confirms and verifies medications. The next shift nurse checks medications and directions. The third check is conducted by the next shift for medication entry and directions. The | |

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| F 329 | Continued From page 25<br>the following: Ativan 0.5 mg by mouth every 8 hours as needed for up to 10 days. The MAR revealed that Resident #7 had received Ativan 0.5 mg by mouth on the following days: 02/04/17, 02/05/17, 02/09/17, 02/12/17, 02/13/17, and 02/26/17.<br><br>Review of most recent comprehensive minimum data set (MDS) dated 02/08/17 revealed that Resident #7 was severely cognitively impaired. The MDS also revealed that Resident #7 had inattention that fluctuated in severity and no other behaviors were noted. The MDS further revealed that Resident #7 received 2 days of anti-anxiety medication.<br><br>Review of the MAR dated 03/01/17 through 03/31/17 revealed the following: Ativan 0.5 mg by mouth every 8 hours as needed for up to 10 days. The MAR revealed that Resident #7 had received Ativan 0.5 mg by mouth on the following days: 03/10/17, 03/11/17, 03/13/17, 03/14/17, 03/16/17, 03/17/17, 03/21/17, and 03/31/17.<br><br>Review of the MAR dated 04/01/17 through 04/30/17 revealed the following: Ativan 0.5 mg by mouth every 8 hours as needed for up to 10 days. The MAR revealed that Resident #7 had received Ativan 0.5 mg by mouth on the following days: 04/03/17 and 04/10/17.<br><br>Observation of Resident #7 on 04/11/17 at 1:31 PM revealed a well-groomed resident sitting in her wheelchair in her room. Resident #7 was smiling and calm.<br><br>Observation of Resident #7 on 04/12/17 at 8:55 AM revealed a well-groomed resident sitting in her wheelchair in her room. Resident #7 was | F 329 | fourth check is completed by an administrative nurse to verify that medications and directions are accurate.<br><br>Quality Assurance/Monitoring: An administrative nurse will audit one resident's admission orders weekly for three weeks and then one resident's admission orders monthly for three months to ensure compliance. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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| F 329 | Continued From page 26<br>smiling and calm as a member of the activity department braided her hair.<br><br>Interview with the Director of Nursing (DON) on 04/12/17 at 3:45 PM revealed that Resident #7 had came back from the hospital with that order. The DON stated after 10 days the order should have been stopped or reevaluated. The DON stated that she would obtain a clarification order and fix the error now.<br><br>Interview with Nurse #1 on 04/13/17 at 9:35 AM revealed that he worked all over the facility and did not necessarily remember putting that specific order in because he put a lot of orders into the electronic medical record. Nurse #1 stated that when he had an order that was to be given for a certain amount of time like this order stated Ativan 0.5 mg by mouth every 8 hours a needed for up to 10 days there was a place in the electronic system that stated "duration" and you would select the duration of the medication in this case it would have been 10 days. Nurse #1 further stated that if you do not specify the duration of the medication it goes to "indefinitely" which meant the order would continue to appear on the MAR until it was changed or discontinued. Nurse #1 stated that he felt like this was just a mistake because he did not recall the day or any other reason why he would not have put the duration in the electronic medical record.<br><br>Interview with the Nurse Practitioner (NP) on 04/13/17 at 11:03 AM revealed that she had been made aware of the error with Resident #7 and she felt like there were no adverse reactions from this medication. | F 329 | | |
| F 332 | 483.45(f)(1) FREE OF MEDICATION ERROR | F 332 | | 5/11/17 |

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| F 332 SS=D | Continued From page 27<br>RATES OF 5% OR MORE<br><br>(f) Medication Errors. The facility must ensure that its-<br><br>(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews the facility failed to maintain a medication error rate less than 5% as evidenced by 2 errors out of 30 opportunities for 2 of 3 residents (Resident #19 and Resident #55) observed during medication pass. This resulted in a facility medication error rate of 6.66%.<br><br>The findings included:<br><br>1. Resident #19 was re-admitted to the facility on 10/20/16 with diagnoses that included hypopituitarism (a decrease in the secretion of the hormones produced by the pituitary gland.)<br><br>Review of a physician order for Resident #19 dated 10/20/16 read, hydrocortisone 10 milligrams (mg) by mouth in the afternoon for hypopituitarism.<br><br>Observation on 04/11/17 at 4:25 PM of Nurse #2 preparing Resident #19's afternoon medication was made. Nurse #2 was observed pulling a card of medication out of the medication cart. The card identified the medication as Hydrocortisone 10 mg tablets. Nurse #2 punched 2 tablets (20 mg) out of the card and placed them in the medication cup on top of the medication cart. After preparing the rest of Resident #19's medication Nurse #2 entered Resident #19's room and administered | F 332 | Resident Affected: On 4/12/2017 when the Director of Nursing was notified by surveyor of concerns from the previous day's med pass, Nurse #2 was suspended and later terminated.<br><br>Other residents with the potential to be affected: All staff nurses received education on the Five Rights of Med Passes by the RN Nurse Supervisor with completion of 5/8/2017. All nurses were checked off on the medication administration skills checklist by 5/11/2017 by the Director of Nursing and RN Supervisors.<br><br>Systemic Changes: Medication administration education and observation by Director of Nursing or Administrative Nursing Staff will occur quarterly. Each nurse will be observed to ensure that they are following the five rights of medication administration.<br><br>Quality Assurance/Monitoring: The Administrator will ensure that the medication administration education and observations are completed quarterly for licensed nurses. Random monitoring will | |

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| F 332 | Continued From page 28<br>the medication that included Hydrocortisone 10 mg 2 tablets.<br><br>Interview with the Director of Nursing (DON) on 04/12/17 at 4:19 PM revealed that Nurse #2 had medication pass competency done upon her hire and was not sure if the pharmacy had observed Nurse #2's medication pass or not. The DON stated she expected medication to be administered using the "5 rights of medication administration", the right medication, the right dose, to the right patient, at the right time, via the right route.<br><br>Interview with Nurse #2 on 04/12/17 at 4:48 PM revealed that she had worked at the facility for 8 months. Nurse #2 stated she did not realize that Resident #19 only received 1 hydrocortisone tablet in the afternoon and it was "just an oversight and nervousness" that led to the error. Nurse #2 stated that facility management staff had completed a medication pass with her when she was hired but the pharmacy had not done one with her.<br><br>Interview with the Nurse Practitioner (NP) on 04/13/17 at 11:03 AM revealed that she had been made aware of the error with Resident #19 and she felt there were no adverse reactions from this medication error.<br><br>2. Resident #55 was readmitted to the facility on 08/15/16 with diagnosis that included chronic obstructive pulmonary disease.<br><br>Review of a physician order for Resident #55 dated 04/10/17 read in part, Mucinex 1200 milligram (mg) by mouth twice a day for 7 days. | F 332 | occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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Observation on 04/11/17 at 4:13 PM of Nurse #2 preparing Resident #55's afternoon medication was made. Nurse #2 was observed to pull a box of medication out of the medication cart. The medication was Mucinex 600 mg tablets. Nurse #2 was observed to place 1 Mucinex 600 mg tablet in a medication cup on top of the medication cart. After preparing the rest of Resident #55's medication Nurse #2 entered Resident #55's room and administered the medications that included Mucinex 600 mg by mouth.

Interview with the Director of Nursing (DON) on 04/12/17 at 4:19 PM revealed that Nurse #2 she had medication pass competency done upon her hire and was not sure if the pharmacy had observed Nurse #2's medication pass or not. The DON stated she expected medication to be administered using the "5 rights of medication administration," the right medication, the right dose, to the right patient, at the right time, via the right route.

Interview with Nurse #2 on 04/12/17 at 4:48 PM revealed that she had worked at the facility for 8 months. Nurse #2 stated she did not realize that Resident #55 received Mucinex 1200 mg and it was "just an oversight and nervousness" that led to the error. Nurse #2 stated that facility management staff had completed a medication pass with her when she was hired but the pharmacy had not done one with her.

Interview with the Nurse Practitioner (NP) on 04/13/17 at 11:03 AM revealed that she had been made aware of the error with Resident #55 and she felt like there were no adverse reactions from this medication.

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| F 463 SS=E | 483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH<br><br>(g) Resident Call System<br><br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -<br><br>(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews the facility failed to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls.<br><br>The findings included:<br><br>1. Observation on 04/11/17 at 9:02 AM of Resident room 204 D (door) revealed that when the call light was pushed the light in the room came on but the light in the hallway did not come on. The main panel at the nurse's station did not sound or light up indicating Resident room 204 D had turned on the call light.<br><br>Interview with Nurse #3 on 04/11/17 at 9:30 AM confirmed that the call light was not on outside the room and was not sounding at the nurse's station. Nurse #3 stated because the call light was not working properly she did not know that the resident in 204 D needed assistance but she would take care of the call light and the resident right now.<br><br>Observation and interview with the Maintenance | F 463 | Residents affected: The call bell in room 204 was repaired on 4/13/2017 and the call bell in room 216 was repaired on 4/12/2017. While the call lights were being repaired, a manual call bell was placed in these rooms for the residents to utilize until the call lights were fully functional.<br><br>Residents with the potential to be affected: An audit of all resident rooms was conducted by the Administrator and Maintenance Director on 4/12/2017 and all other call lights were functioning properly.<br><br>Systemic Changes: Staff members were educated by the Administrator on the proper use of the Maintenance Work Order forms and proper procedure for alerting maintenance of issues related to the call light system by 5/8/2017. Staff were also educated on placing temporary call bells at bedside if the call lights are | 5/8/17 |

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| F 463 | Continued From page 31<br>Director (MD) on 04/11/17 at 9:36 AM was made. The Maintenance Director entered Resident room 204 D and stated he knew what was wrong with the call light. The MD reset the bathroom switch and the call light in the hallway then came on. The MD stated that the internal switch and connections were old and worn down and if the bathroom light did not get completely reset it would cause the call light in the room not to function properly. After the MD reset the bathroom switch the call light in the room, in the hallway, and at the nurses station were working.<br><br>In a follow up interview with MD on 04/12/17 at 2:35 PM revealed that the facility had 2-3 different types of call bell's within the facility. The MD explained that room 204 D had the old style level pull system in the bathroom and the internal contacts were worn down and that caused the call light in the room and in the hallway to not work consistently. The MD stated he was aware of the issue and had ordered the replacement part and when the part came in, it was the wrong part. The MD stated he reordered the correct part and it had arrived to the facility but he was unable to repair it because of the different wiring system between the old part and the new part. The MD stated it could short out the rest of the call lights in the facility so someone from the parts company was going to come and help install the new part. The MD stated that either he or his assistant checked each call bell every week to make sure they were all working properly, the MD stated his assistant had completed the call light check on Monday and no issues were noted.<br><br>Interview with the Administrator and Director of Nursing on 04/12/17 at 4:06 PM revealed that they were not aware that the call light system was | F 463 | not properly functioning.<br><br>Quality Assurance/Monitoring: The Maintenance Director performs an audit of all call lights weekly for one month and then monthly times three months. These audits will be reviewed by the Administrator. The results of these audits will be reported to the Quality Assurance Committee. Continued areas of concern will be addressed by the QA Committee for further action plans as indicated. | |

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not working properly. The administrator stated he absolutely would have wanted to have been notified so he could have notified the DON and the resident could have gotten another way to call for assistance. The administrator stated it was his expectation that all residents had a means of calling for assistance.

Interview with Maintenance Assistant (MA) on 04/12/17 at 4:57 PM revealed that he had checked the call lights on 04/10/17 and there was no issues with Room 204 D the light was working properly when he checked it. The MA stated if there was a problem then he would either fix the issue or if he was unable to fix the issue he would let his supervisor know.

A follow up interview was conducted on 04/13/17 at 9:21 AM with Nurse #3, she stated that they have had problems with Resident Room 204 D call light not working properly in the past and had a outside company come and look at the system in that room but to her knowledge they have not had any issues with any other rooms.

2. Observation of Resident room 204 W (window) on 04/11/17 at 9:02 AM revealed that when the call light was pushed the light in the room did not turn on, the light in hallway did not turn on, and the main panel at the nurses station did not sound or light up indicating the light in Resident Room 204 W had been turned on.

Observation and interview with the Maintenance Director (MD) on 04/11/17 at 9:36 AM was made. The MD confirmed that Resident Room 204 W call light was not working properly. The MD worked with the call light and determined it was a bad call cord. The MD replaced the call cord in

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Resident room 204 W and the call light than began working correctly.

In a follow up interview with MD on 04/12/17 at 2:35 PM revealed that his assistant had checked the call lights on Monday and to his knowledge there was no issues. The MD stated that the process for repairs was, when anyone discovered something that was not working properly they filled out a work order and placed it in the box on his door and either he or his assistant would take care of it. The MD stated he had no recent work orders for call lights that were not working.

Interview with the Administrator and Director of Nursing on 04/12/17 at 4:06 PM revealed that they were not aware that the call light system was not working properly. The administrator stated he absolutely would have wanted to have been notified so he could have notified the DON and the resident could have gotten another way to call for assistance. The administrator stated it was his expectation that all residents had a means of calling for assistance.

Interview with Maintenance Assistant (MA) on 04/12/17 at 4:57 PM revealed that he had checked the call lights on 04/10/17 and there was no issues with Room 204 D the light was working properly when he checked it. The MA stated if there was a problem then he would either fix the issue or if he was unable to fix the issue he would let his supervisor know.

3. Observation of Resident Room 216 D (door) on 04/11/17 at 10:14 AM revealed that when the call light was pushed the light in room did not turn on, the light in the hallway did not turn on, and the main panel at the nurse's station did not sound or

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light up indicating the light in Resident Room 216 D had been turned on.

Observation of Resident Room 216 D on 04/12/17 at 8:58 AM revealed that when the call light was pushed the light in room did not turn on, the light in the hallway did not turn on, and the main panel at the nurse's station did not sound or light up indicating the light in Resident Room 216 D had been turned on.

Observation and Interview with the Maintenance Director (MD) on 04/12/17 at 3:00 PM confirmed that the call light in Resident room 216 D was not working. The MD confirmed that when pushed, the call light in the room did not come on, the light in the hallway did not come on, and the main panel at the nurse's station did not sound or light up indicating the call light in Resident Room 216 D had been turned on. The MD stated his assistant had checked the call lights on Monday and he could not recall if there was issue or not. The MD stated he believed the box in the wall was bad and he would have to replace it.

Interview with the Administrator and Director of Nursing on 04/12/17 at 4:06 PM revealed that they were not aware that the call light system was not working properly. The administrator stated he absolutely would have wanted to have been notified so he could have notified the DON and the resident could have gotten another way to call for assistance. The administrator stated it was his expectation that all residents had a means of calling for assistance.

Interview with Maintenance Assistant (MA) on 04/12/17 at 4:57 PM revealed that he had checked the call lights on 04/10/17 and Resident

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| F 463 | Continued From page 35<br>Room 216 D was not working when he checked the call lights. The MA stated he did not tell the MD which was his supervisor because "it had slipped my mind." The MA stated that actually he discovered that the call bell in Resident Room 216 D was not working last Thursday when he was checking the call lights. The MA stated that was not something he could fix so he had told his supervisor the MD in passing. The MA stated he had not filled out the work order but had just told the MD in passing and maybe he had not heard him clearly. | F 463 | | |
| F 490 SS=E | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have a medication error rate of 5 percent or greater and resulted in observations during medication pass of a medication error rate of 6.66 percent. The facility also failed to ensure communication occurred from staff to administration to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls.<br><br>Findings included: | F 490 | Resident Affected: On 4/12/2017 when the Director of Nursing was notified by surveyor of concerns from the previous day's med pass, Nurse #2 was suspended and later terminated.<br><br>Other residents with the potential to be affected: All staff nurses received education on the Five Rights of Med Passes by the RN Nurse Supervisor with completion of 5/8/2017. All nurses were checked off on the medication administration skills checklist by 5/15/2017 by the Director of Nursing and RN Supervisors. | 5/8/17 |

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| F 490 | Continued From page 36<br><br>Cross refer to F 332: Assure facility had a medication error rate which were not 5 percent or greater: Based on observations, record reviews, and staff interviews the facility failed to maintain a medication error rate less than 5% as evidenced by 2 errors out of 30 opportunities for 2 of 3 residents (Resident #19 and Resident #55) observed during medication pass. This resulted in a facility medication error rate of 6.66%.<br><br>F 332 was originally cited during the recertification survey of 03/24/16 for failure to ensure that the medication error rate was 5% or below as evidence by 2 errors out of 27 opportunities resulting in a medication error rate of 7.4% for 1 of 7 residents observed during medication pass (Resident # 105).<br><br>Cross refer to F 463: Based on observations, record reviews, and staff interviews the facility failed to ensure the call light system was functioning properly for 3 resident rooms (Rooms 204 D, Room 204 W, and 216 D) on 1 of 3 resident halls. | F 490 | Systemic Changes: Medication administration education and observation by Director of Nursing or Administrative Nursing Staff will occur quarterly.<br><br>Quality Assurance/Monitoring: The Administrator will ensure that the medication administration education and observations are completed quarterly for licensed nurses. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |
| F 520 SS=E | 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; | F 520 | | 5/11/17 |

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| F 520 | Continued From page 37<br><br>(iii) At least three other members of the facility's 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 observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April of 2016. This was for one recited deficiency which was originally cited in March of 2016 on a Recertification survey and subsequently recited in | F 520 | Resident Affected: On 4/12/2017 when the Director of Nursing was notified by surveyor of concerns from the previous day's med pass, Nurse #2 was suspended and later terminated.<br><br>Other residents with the potential to be affected: All staff nurses received | |

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| F 520 | Continued From page 38<br>April of 2017 on the current recertification survey. The deficiency was in the area to assure the facility did not have a medication error rate of 5 percent or greater. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referred to:<br><br>F 332 Assure facility did not have medication error rates of 5 percent or greater: Based on observations, record reviews, and staff interviews the facility failed to maintain a medication error rate less than 5% as evidenced by 2 errors out of 30 opportunities for 2 of 3 residents (Resident #19 and Resident #55) observed during medication pass. This resulted in a facility medication error rate of 6.66%.<br><br>During the recertification survey of 03/24/16 the facility was cited for failure to ensure that the medication error rate was 5% or below as evidence by 2 errors out of 27 opportunities resulting in a medication error rate of 7.4% for 1 of 7 residents observed during medication pass (Resident # 105).<br><br>During an interview on 04/13/17 at 2:22 PM with the Administrator and Director of Nursing they explained the Quality Assurance and Assessment Committee used plans of correction to monitor for a certain period of time to prevent repeat deficiencies. The Administrator stated they had done training for nursing staff regarding medication administration and the pharmacy had done medication pass training for staff. He stated | F 520 | education on the Five Rights of Med Passes by the RN Nurse Supervisor with completion of 5/8/2017. All nurses were checked off on the medication administration skills checklist by 5/11/2017 by the Director of Nursing and RN Supervisors.<br><br>Systemic Changes: Medication administration education and observation by Director of Nursing or Administrative Nursing Staff will occur quarterly. Each nurse will be observed to ensure that they are following the five rights of medication administration.<br><br>Quality Assurance/Monitoring: The Administrator will ensure that the medication administration education and observations are completed quarterly for licensed nurses.<br><br>In addition, the results of the nurse skills checklists will be reviewed during the monthly QA meeting to determine if nursing needs further education or more frequent oversight to ensure a medication error rate of less than 5%. Random monitoring will occur and will be reported to the Quality Assurance Committee on an ongoing basis until the issue has been resolved. | |

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| F 520 | Continued From page 39<br>he was not sure why staff had failed to administer medications to achieve a rate less than 5 percent but more work would have to be done. The Director of Nursing stated she did not know why nursing staff had failed to achieve a medication error rate of less than 5 percent but it would be addressed further with plans to correct it. | F 520 | | |