STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 04/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 000	INITIAL COMMENTS No deficiences were cited as aresult of the complaint investigation survey on 4/7/17 Event ID #v7m511	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		5/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, physician assistant and physician interviews, the facility failed to notify the physician that a prescribed IV antibiotic was unavailable for 1 of 4 sampled residents, reviewed for medication (Resident #253). Findings included: Resident #253 was admitted on 3/31/17. Her diagnoses included left leg wound infection. There was no Minimum Data Set assessment available for review. The admission assessment indicated resident ' s intact cognition and presence of the left leg wound with dressing. Review of hospital ' s discharge documents dated 3/31/17, revealed Resident #253 was diagnosed with MSSA (methicillin susceptible staphylococcus aureus) infection of her left leg wound and the discharge order indicated Oxacillin (antibiotic) 2 g (gram) in 0.9% (percent)	F 157	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1.Resident affected Resident # 253 was discharged home on 4/19/2017 per discharge plan. 2.Residents with potential to be affected a.All other residents with IV antibiotics orders were reviewed and the antibiotics were available in the facility for	

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F 157	Continued From page 2 sodium chloride solution 100 ml (milliliter) IV (intravenously) every 4 hours for 12 days. Review of Resident 253 ' s physician ' s order dated 3/31/17, revealed the order for Oxacillin 2 g in 0.9% sodium chloride solution 100 ml IV every 4 hours for 12 days. Review of Resident 253 ' s interim plan of care, dated 3/31/17, revealed the resident was admitted with the left leg wound infection and to continue the treatment with medication administration according to physician ' s order. Record review of the nurses ' notes dated 4/2/17 at 1:38 PM, revealed the staff received information from pharmacy that the Oxacillin was not available for Resident #253 from the main or back up pharmacy. The first attempt to obtain Oxacillin was made on 3/31/17 at 6 PM and the second on 4/1/17 with no results. On 4/1/17 the pharmacy technician recommended to notify the physician to request the alternative medication due to shortage of the antibiotic Oxacillin. Review of Resident 253 ' s physician ' s order, dated 4/4/17, revealed an order to discontinue Oxacillin and start Cefazolin (antibiotic) 1 g with 50 ml of normal saline solution IV every 12 hours for 14 days. Review of the pharmacy communication form, dated 4/5/17, revealed that Oxacillin was not available and Cefazolin recommended. Review of Resident 253 ' s Medication Administration Record (MAR) for March and April 2017 revealed Oxacillin was not marked as administered between 3/31/17 and 4/3/17. On	F 157	administration as ordered. b.For residents with IV antibiotics on admission the process of securing the medication is: Physician orders are faxed to pharmacy, if the medication in unavailable from pharmacy then charge nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will contact the physician immediately for an alternative order before the next scheduled dose. 3.Systemic Changes: a.100% Education/in-servicing of all licensed nurses on Procuring medications and immediate Physician notification if the medication is unavailable was initiated on 4/7/2017 by the Clinical Competency Coordinator and the Director of Nursing. Licensed Nurses not educated/in-serviced by 5/4/2017 will be removed from the schedule until their education/in-service is complete. b.New licensed nurses will be educated on procuring medications and immediate physician notification if medication is unavailable during new hire orientation. c.Upon admission the Physician orders are faxed to pharmacy, if the medication is unavailable from pharmacy the nurse calls the backup pharmacy. If medication is unavailable from the backup pharmacy the charge nurse will notify the physician immediately and obtain an alternate order prior to the next scheduled dose.	

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F 157	Continued From page 3 4/4/17 at 9:00 PM, the MAR indicated the resident received Cefazolin 1 g with 50 ml normal saline solution IV. Record review of the nurses ' notes, dated 4/4/17 on third shift, revealed that Resident #253 received first dose of antibiotic Cefazolin. On 4/5/17 at 8:10 AM, during the observation/interview, Resident #253 was in her room and was on isolation precautions. The resident indicated she had received an antibiotic on 03/31/17 in hospital and not again until 4/4/17. On 4/5/17 at 8:20 AM, during an interview, Nurse #4 indicated that she was aware Resident #253 had an order for Oxacillin but did not receive it because it was not available on 4/3/17. The nurse indicated the unit manager and physician were notified on 4/3/17 and that she did not try to obtain Oxacillin. On 4/5/17 at 8:30 AM, during an interview, Nurse #1 indicated that on 3/31/17 she sent a fax with Resident 253 ' s medications request to the pharmacy and transcribed all the orders from the hospital discharge documents, including Oxacillin, to the MAR. She stated that she saw the new order for Cefazolin on 4/4/17. On 4/5/17 at 9:10 AM, during an interview, the Physician Assistant (PA), indicated that she worked Monday through Friday and there was physician on call available during weekend. She expected the staff to notify physician on call in regards to unavailable medications. The PA added that lack of antibacterial therapy could delay the wound healing.	F 157	d.The floor nurses will utilize the medication availability audit tool to validate that the medication is available in the facility. The Assistant Director of Nursing and the Unit Manager will review the audit tool to ensure availability of medications. This will be done daily for 7 days, weekly X3 weeks and then monthly for 3 months. 4.Monitoring a.The Assistant Director Of Nursing and the Nurse Manager/Unit Manager will report any findings to the Director of Nursing. The Director of Nursing will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance has been maintained.	

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F 157	Continued From page 4	F 157		

On 4/5/17 at 9:20 AM, during an interview, the Assistant Director of Nursing indicated she expected the staff to communicate with physician on call if the physician ' s order could not be completed.

On 4/5/17 at 9:30 AM, during an interview, the Physician indicated that on 3/31/17 he approved the Oxacillin order for Resident #253 at her admission. He was not on call during the weekend and did not know the resident did not receive antibiotic. The Physician was notified about this situation on Monday, 4/3/17, and he stated he communicated with hospital clinic to choose better antibiotic and ordered Cefazolin on 4/4/17. He stated that interruption in antibacterial treatment could delay the resident ' s wound healing. The physician expected the staff during weekend to notify by phone the physician on call about unavailable medication and to ask for alternative medication.

On 4/5/17 at 3:30 PM, during an interview, Nurse #8 indicated that he remembered Resident 253 ' s admission on Friday, 3/31/17. He communicated with the physician to approve all the orders. On 3/31/17 at 6 PM he called the pharmacy in regards to a missing dose of Oxacillin and was told that it was not available from the main pharmacy. The nurse communicated with pharmacy technician several times and received information that Oxacillin was not available due to nationwide shortage. The nurse did not call the physician on call to report the issue. He completed the communication to physician book to request alternative medications. The nurse passed the information that the Oxacillin was not administered to the next shift staff.

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F 157	Continued From page 5 On 4/5/17 at 3:40 PM, during an interview, Nurse #5 indicated that she worked on 3/31/17 and recalled that Nurse #8 communicated to the pharmacy several times in regards to medications for Resident #253, but she was not involved in that situation. She worked with the resident on 4/1/17, 4/2/17 and remembered that the Oxacillin was not available for administration. Nurse #5 notified the Weekend Supervisor on 4/1/17 and did not notify the physician on call because she assumed the physician was already notified by other staff. On 4/5/17 at 3:50 PM, during an interview, the Weekend Supervisor indicated that she worked as Weekend Nurse Supervisor for the entire building from 3/31/17 to 4/2/17. She could recall that Nurse #8 communicated with the pharmacy, but nobody brought to her attention that Resident #253 did not receive the antibiotic. The Nurse Supervisor did not know that the Nurse #8 completed the communication book and did not talk to the physician on call. She expected the staff during weekend to notify by phone the physician on call about unavailable medication and to ask for alternative medication.	F 157		
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.	F 224		5/5/17

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F 224	Continued From page 6 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, physician assistant and physician interviews, the facility neglected to provide intravenous (IV) antibiotic treatment for a wound infection until four days after it was ordered for 1 of 4 sampled residents, reviewed for medication (Resident #253). Findings included: Resident #253 was admitted on 3/31/17. Her diagnoses included left leg wound infection. There was no Minimum Data Set assessment available for review. The admission assessment indicated resident ' s intact cognition and presence of the left leg wound with dressing. Review of hospital ' s discharge documents dated 3/31/17, revealed Resident #253 was diagnosed with methicillin susceptible staphylococcus aureus infection of her left leg wound and the discharge order indicated Oxacillin (antibiotic) 2 g (gram) in 0.9% (percent) sodium chloride solution 100 ml (milliliter) IV (intravenously) every 4 hours for 12 days.	F 224	1.Resident affected Resident # 253 was discharged home on 4/19/2017 per discharge plan. 2.Residents with potential to be affected a.All other residents with IV antibiotics orders were reviewed and the antibiotics were available in the facility for administration as ordered. b.For residents with IV antibiotics on admission the process of securing the medication is: Physician orders are faxed to pharmacy, if the medication in unavailable from pharmacy then charge nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will notify the physician immediately for an alternative order prior to the next scheduled dose. 3.Systemic Changes:	

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F 224	Continued From page 7 Review of Resident 253 ' s physician ' s order dated 3/31/17, revealed the order for Oxacillin 2 g in 0.9% sodium chloride solution 100 ml IV every 4 hours for 12 days. Review of Resident 253 ' s interim plan of care, dated 3/31/17, revealed the resident was admitted with the left leg wound infection and to continue the treatment with medication administration according to physician ' s order. Record review of the nurses ' notes dated 4/2/17 at 1:38 PM, revealed the staff received information from pharmacy that the Oxacillin was not available for Resident #253 from the main or back up pharmacy. The first attempt to obtain Oxacillin was made on 3/31/17 at 6 PM and the second on 4/1/17 with no results. On 4/1/17 the pharmacy technician recommended to notify the physician to request the alternative medication due to shortage of the antibiotic Oxacillin. Review of Resident 253 ' s physician ' s order, dated 4/4/17, revealed an order to discontinue Oxacillin and start Cefazolin (antibiotic) 1 g with 50 ml of normal saline solution IV every 12 hours for 14 days. Review of the pharmacy communication form, dated 4/5/17, revealed that Oxacillin was not available and Cefazolin recommended. Review of Resident 253 ' s Medication Administration Record (MAR) for March and April 2017 revealed Oxacillin was not marked as administered between 3/31/17 and 4/3/17. On 4/4/17 at 9:00 PM, the MAR indicated the resident received Cefazolin 1 g with 50 ml normal saline solution IV.	F 224	a.100% Education/in-servicing of all licensed nurses on neglect for failure to provide IV antibiotics when and as ordered was initiated on 4/7/2017 by the Clinical Competency Coordinator and the Director of Nursing. Licensed Nurses not educated/in-serviced by 5/4/2017 will be removed from the schedule until their education/in-service is complete. New licensed nurse will be educated on neglect for failure to provide IV antibiotics when and as ordered during new hire orientation. b.100% Education/in-servicing of all licensed nurses on Procuring medications and Physician notification if the medication is unavailable was initiated on 4/7/2017 by the Clinical Competency Coordinator and the Director of Nursing. Licensed Nurses not educated/in-serviced by 5/4/2017 will be removed from the schedule until their education/in-service is complete. c.New licensed nurses will be educated on neglect, procuring medications and physician notification if medication is unavailable during new hire orientation. d.Upon admission the Physician orders are faxed to pharmacy, if the medication is unavailable from pharmacy the nurse calls the backup pharmacy. If medication is unavailable from the backup pharmacy the charge nurse will notify the physician immediately and obtain an alternate order prior to the next scheduled dose.	

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F 224	Continued From page 8 Record review of the nurses ' notes, dated 4/4/17 on third shift, revealed that Resident #253 received first dose of antibiotic Cefazolin. On 4/5/17 at 8:10 AM, during the observation/interview, Resident #253 was in her room and was on isolation precautions. The resident indicated she had received an antibiotic on 03/31/17 in hospital and not again until 4/4/17. She asked the staff about IV antibiotic (could not recall the name of medication) to continue the treatment and was told the medication was not available. The resident felt that antibacterial treatment was one of her purposes to stay in the facility. On 4/5/17 at 8:20 AM, during an interview, Nurse #4 indicated that she was aware Resident #253 had an order for Oxacillin but did not receive it because it was not available on 4/3/17. The nurse indicated the unit manager and physician were notified on 4/3/17 and that she did not try to obtain Oxacillin. On 4/5/17 at 8:30 AM, during an interview, Nurse #1 indicated that on 3/31/17 she sent a fax with Resident 253 ' s medications request to the pharmacy and transcribed all the orders from the hospital discharge documents, including Oxacillin, to the MAR. She stated that she saw the new order for Cefazolin on 4/4/17. On 4/5/17 at 9:10 AM, during an interview, the Physician Assistant (PA), indicated that she worked Monday through Friday and there was physician on call available during weekend. She expected the staff to notify physician on call in regards to unavailable medications. The PA added that lack of antibacterial therapy could	F 224	e.The floor nurses will utilize the medication availability audit tool to validate that the medication is available in the facility. The Nurse Managers/Unit Managers will review the audit tool to ensure availability of medications. This will be done daily for 7 days, weekly X3 weeks and then monthly for 3 months. The ADON and Nurse Managers are responsible for monitoring for compliance. 4.Monitoring a.The Assistant Director Of Nursing and Unit Managers/Nurse Managers will report any findings to the Director of Nursing. The Director of Nursing will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance has been maintained.	

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delay the wound healing.

On 4/5/17 at 9:20 AM, during an interview, the Assistant Director of Nursing indicated she expected the staff to communicate with physician on call if the physician ' s order could not be completed.

On 4/5/17 at 9:30 AM, during an interview, the Physician indicated that on 3/31/17 he approved the Oxacillin order for Resident #253 at her admission. He was not on call during the weekend and did not know the resident did not receive antibiotic. The Physician was notified about this situation on Monday, 4/3/17, and he stated he communicated with hospital clinic to choose better antibiotic and ordered Cefazolin on 4/4/17. He stated that interruption in antibacterial treatment could delay the resident ' s wound healing. The physician expected the staff during weekend to notify by phone the physician on call about unavailable medication and to ask for alternative medication.

On 4/5/17 at 3:30 PM, during an interview, Nurse #8 indicated that he remembered Resident 253 ' s admission on Friday, 3/31/17. He communicated with the physician to approve all the orders. On 3/31/17 at 6 PM he called the pharmacy in regards to a missing dose of Oxacillin and was told that it was not available from the main pharmacy. The nurse communicated with pharmacy technician several times and received information that Oxacillin was not available due to nationwide shortage. The nurse did not call the physician on call to report the issue. He completed the communication to physician book to request alternative medications. The nurse passed the information

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F 224	Continued From page 10 that the Oxacillin was not administered to the next shift staff. On 4/5/17 at 3:40 PM, during an interview, Nurse #5 indicated that she worked on 3/31/17 and recalled that Nurse #8 communicated to the pharmacy several times in regards to medications for Resident #253, but she was not involved in that situation. She worked with the resident on 4/1/17, 4/2/17 and remembered that the Oxacillin was not available for administration. Nurse #5 notified the Weekend Supervisor on 4/1/17 and did not notify the physician on call because she assumed the physician was already notified by other staff. On 4/5/17 at 3:50 PM, during an interview, the Weekend Supervisor indicated that she worked as Weekend Nurse Supervisor for the entire building from 3/31/17 to 4/2/17. She could recall that Nurse #8 communicated with the pharmacy, but nobody brought to her attention that Resident #253 did not receive the antibiotic. The Nurse Supervisor did not know that the Nurse #8 completed the communication book and did not talk to the physician on call. She expected the staff during weekend to notify by phone the physician on call about unavailable medication and to ask for alternative medication.	F 224		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care	F 279		5/5/17

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plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and

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F 279	Continued From page 12 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to provide a comprehensive care plan for 3 of 4 sampled residents who required splints (#55, # 92, and #160) and 1 of 3 sampled residents with a pressure ulcer (#92) and failed to update care plans with measurable goals and individualized approaches. (#55, # 92) Findings included: Resident number #92 was admitted to the facility on 7/9/14 with a diagnosis in part, of diabetes mellitus, hemiparesis and left sided weakness, stage IV pressure ulcer with osteomyelitis. The most recent quarterly Minimum Data Set (MDS) dated 1/2/17, revealed moderate cognitive impaired, one side of her body with upper and lower range of motion impairment. Review of all of Resident #92 care plans revealed, a care plan for "Impaired skin integrity" dated 7/11/16 and amended to a stage IV pressure ulcer to the thumb (no date). The most recent review date of remaining care plans was 10/16/16, the care plans had no goal date and lacked an individualized approach. No care plan	F 279	1.Resident affected a.Resident # 55, #92, # 160 care plans were updated to reflect the splint usage. Resident # 92-care plan was updated for pressure ulcer. Care plans for resident # 55 and #92 were reviewed and updated for measurable goals and individualized approach. All this was accomplished on 4/6/2017. 2.Residents with potential to be affected a.On 4/6/2017, Nurse Managers and the Case Mix Director reviewed all residents with splints and/or braces and their care plans were updated for measurable goals and individualized approach as needed. b.On 4/6/2017, the Skin Integrity Nurse reviewed care plans for all residents with wounds and/or pressure ulcers. The Skin Integrity Nurse revised/updated the care plans for measurable goals and	

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F 279	Continued From page 13 was initiated for the splint to the left hand. Record review of wound care nursing note dated 12/19/16, revealed a stage II pressure ulcer to left thumb. Record review of the rehabilitation therapy note dated 03/07/17, revealed to wear "Soft left posey [sic] elbow splint [a sling] and bladder forearm splint [A fore arm splint that wraps between the thumb and index finger that can be inflated to custom fit the patient]." The restorative aide was trained to apply the splint. During interview on 4/6/17 at 9:10 AM, the MDS nurse reviewed the current care plans and indicated that the care plans should have been updated during the assessment on quarterly assessment on 1/2/17. She indicated she did not know Resident #92 wore a splint and stated the wound care nurse was responsible for completing the care plan for the pressure ulcer. She stated the MDS nurses were not responsible for initiating the new care plans for the splints or the pressure ulcer. It was the responsibility of the facility nurse or the wound care nurse. The Director of Nursing supervised the program and was responsible for the accuracy of the care plans. During interview on 4/6/17 at 9:37 AM, the Wound Care Nurse (WCN) indicated there was an interdisciplinary team (IDT) meeting every morning. The team discussed the new orders and the MDS nurse created the care plan. The WCN indicated he updated the pressure ulcer care plans between assessments. During interview on 04/07/17 at 10:53 AM, Nurse #9 indicated the IDT updated the care plans during the morning meeting. The interim care plan was completed by the floor during on admission. During interview on 04/07/17 at 11:16 AM, the Unit Manager indicated the interim care plans	F 279	individualized approach as needed. 3.Systemic Changes. a.100% education for all Licensed Nurses on updating care plans began on 4/19/2017 by the Clinical Competency Coordinator and the Director of Nursing. Licensed Nurses not educated by 5/4/2017 will be removed from the schedule until their education is complete. New licensed nurses will be educated on updating care plans during new hire orientation. b.The Skin integrity nurse and/or unit manager will update the wound care plans with changes to treatment orders, improvements and/or deterioration in a wound. c.The Licensed Nurse and/or Unit Manager Implement, review and or revise the resident care plan and goal based on the physician orders / therapy orders for restorative nursing. d.The Assistant Director of Nursing and Unit Managers will review new restorative orders/ referrals and recommendations to ensure care plans are updated for measurable goals and individualized approach. This will be done daily for 7 days, then weekly for 3 weeks and then monthly for 3 months. e.The Assistant Director of Nursing, Unit Managers and the Wound Nurse will review the care plans for the residents	

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F 279	Continued From page 14 were initiated by the admitting nurse. Care plans were updated three ways by the nursing staff, during the morning clinical IDT meeting, or during the annual or quarterly assessment. The admitting nurse completed the interim care plan. The floor nurse also notified the MDS nurse of the order changes. The MDS nurse updated the care plan. During the morning IDT meeting the residents new orders were reviewed and clinical changes were shared and the MDS nurse updated the care plan and printed the final care plan. The MDS nurse reviewed and up dated the annual and quarterly care plans. During interview on 04/07/17 at 1:13 PM, the Nurse Consultant indicated the interim care plan was completed by the admitting nurse. The IDT team reviewed the new orders and updated and changed the care plan. All care plans were reviewed and implemented by the IDT. The Director of Nursing was not available for interview on 04/07/2017 at 1:14 PM or prior to exit at 3:00PM Findings included: 2. Resident #55 was admitted to the facility on 12/29/15 with a readmission date of 7/14/16. Diagnoses included, in part, stroke with right side weakness and contractures to upper and lower extremities. The Minimum Data Set (MDS) annual assessment dated 1/10/17 indicated Resident #55 had upper and lower bilateral extremity impairment.	F 279	with wounds and/or pressure ulcers for updates and measurable goals and individualized approach daily for 7 days, then weekly for 3 weeks then monthly for 3 months. 4.Plan to Monitor. a.The Assistant Director of Nursing, Unit Managers and the Wound Nurse will report any findings to the Director of Nursing. The Director of Nursing will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee for review and recommendations monthly until 3 months of consecutive compliance.	

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A review of the care plans revealed Resident #55 had no specific care plan regarding the splint application.
An interview with Nurse #5 on 4/4/17 at 2:20 PM, confirmed there was no information regarding splints on a care plan.

An interview with the Unit Manager on 4/7/17 at 2:30 PM, indicated the care plan need to be updated and accurate to reflect the care needed for the residents.

The Director of Nursing was unavailable for an interview at the time of exit on 4/7/17.

3. Resident admitted on 2/1/16. The diagnoses included cerebral vascular accident and left side hemiplegia.

Review of the physician ' s order and restorative therapy referral, dated 10/14/16, revealed Resident #160 was to wear the left elbow/hand splint daily for 6 hours for left hand range of motion limitation

Review of the Restorative Therapy Referral, dated 10/18/16, revealed the elbow splint/resting hand splint. The goals for restorative program were to complete gentle passive range of motion (PROM) to the left hand wrist and fingers. Then put left resting hand splint. Resident would tolerate resting hand splint for at least 4 hours daily. Complete gentle PROM to elbow and shoulder in all planes, then put left elbow splint. Resident will tolerate splint for at least 4 hours daily 6 times a week.

The Minimum Data Set (MDS) assessment,

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F 279	Continued From page 16 dated 1/10/17, indicated the resident required total care with activities of daily living. Resident 160 ' s cognition was intact. The MDS coded that resident had joint contracture. Review of the care plan, dated 1/24/17, identified the problem as self-care deficits with activities of daily living (ADL ' s), related to cerebral vascular accident with hemiplegia, impaired mobility and general weakness. He required extensive to total assistance with ADLs. The goal included the resident ' s need would be met by staff. The resident would be kept clean, dry, properly dressed and odor free. The interventions included showers per schedule, nail care, physical and occupational therapy (PT/OT) as ordered and encouragement for him to participate in ADLS. There was no documentation of contracture or splint application on the care plan. During an interview on 4/6/17 at 9:36 AM, the MDS nurse indicated on the annual MDS, dated 1/10/17, Resident #160 was coded for range of motion (ROM) and splint /brace application. She was unaware of who was responsible for updating the care plan. During an interview on 4/6/17 at 11:50AM, the Administrator indicated the expectation was that residents should wear splints in accordance to physician's order, the care plan should be updated and reflected the frequency for splint application and staff responsible. He added that if there were changes in residents ' condition, they should be re-evaluated by therapy.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		5/5/17

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F 281	Continued From page 17 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to transcribe physician consult orders for 1 of 1 residents (Resident #163). Findings included: Resident #163 was admitted on 2/20/17. Diagnoses included, in part, tibia/fibula fracture to left leg. The Minimum Data Set dated 3/20/17, 30-day assessment revealed the resident was severely cognitively impaired. The resident required extensive assistance with one staff assisting with all activities of daily living (ADLs) and had an impairment to the lower extremity on one side. A review of the care plan for Resident #163 revealed the resident was at risk for impaired circulation and skin impairment related to a cast to the right lower extremity (RLE). The interventions included to check edges of the cast and all skin areas, monitor for swelling and circulatory impairment. A record review revealed the resident was seen by a vascular surgeon on 3/20/17 for increased swelling to the RLE. The consult revealed recommendations to keep RLE elevated on two pillows.	F 281	1.Immediate corrective action taken for this alleged deficient practice includes: a.Resident # 163 physician orders where updated on 4/5/2017. 2.Resident with potential to be affected. a.The Residents charts have reviewed for consult recommendations with in the past 30 days with orders written as needed. 3.Measures put into place to assure that the alleged deficient practice does not recur include: a.Education began on 4/7/2017, by the Clinical Competency Coordinator, Director of Health Services and/or Nurse Managers, related to follow up on recommendation made by outside consult services for Licensed Nurses. The education included writing physician orders and updating the resident specific care guides for Certified Nursing Assistance. Licensed Nurses not educated by 5/4/2017 will be removed from the schedule until their education is complete.	

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F 281	Continued From page 18 An observation of Resident #163 on 4/3/17 at 2:45 pm revealed the resident was sleeping. There was a full length cast from the foot to the upper thigh on the RLE and it was not elevated. There were no pillows at the foot of bed. An observation of Resident #163 on 4/4/17 at 10:00 am revealed the resident was lying in bed. The casted RLE was not elevated. There were no pillows at the foot of the bed. An observation of Resident #163 on 4/5/17 at 9:30 am revealed the resident was lying in bed sitting upright. The casted RLE was not elevated. There were no pillows at the foot of the bed. An interview with the Physician Assistant (PA) was conducted on 4/5/17 at 9:53 am. The consult was reviewed with the PA from 3/20/17. The PA reported when a resident had a consult, the consult was reviewed upon return by the physician or PA. If there were any recommendations, the physician or the PA would write an order. The PA reported she told the staff verbally about elevating Resident #163 ' s RLE. The PA reported she should have written an order. An interview with NA #1 on 4/5/17 at 10:05 am revealed the resident had a cast on his right leg. NA #1 reported the aides do foot care to his feet by washing them and keeping them moisturized. NA #1 reported the staff used the care guide book to know how to take care of the residents on their assignment. The care guide was reviewed with NA #1 at this time. There was no information regarding elevating the RLE. NA #1 stated she was not aware of the resident having to have the	F 281	b.The education for follow up on consult recommendations has been added to the new partner orientation for licensed nurses. c.The Licensed Nurse will complete the Physician Consult Order review, which identifies if a resident has a recommendation and if the recommendation was followed through with daily. d.The Director of Health Services, Assistant Director of Health Services and/or Nurse Manager will review the Physician Consult Order review to validate the recommendations have been completed. The Director of Health Services, Assistant DHS and/or nurse managers review the Physician Consult Order review daily for 7 days, weekly for 3 weeks then monthly thereafter. 4.Monitoring put in place to assure the alleged deficient practice does not recur includes: The Director of Nursing will present the review of the Physician Consult Order to the quality improvement and performance improvement committee for review and revision monthly until 3 months of continued compliance sustained.	

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F 281	Continued From page 19 RLE elevated with two pillows. An interview with Nurse #4 on 4/5/17 at 10:20 am revealed at one point we were elevating his leg but she was not sure if that order was in place still. Nurse #4 stated the resident was having some swelling to the RLE and he was sent out for a vascular consult. The treatment administration record (TAR) was reviewed. Nurse #4 reported the nursing staff was to monitor the cast to right lower extremity every day to ensure there was no space between the cast and foot/thigh, and to assess for swelling. Nurse #4 confirmed there was no order to elevate the RLE with two pillows. An interview was conducted with the Director of Nursing (DON) on 4/6/17 at 11:30 am. The DON reported her expectation was that the PA and physicians should transcribe orders for any consult recommendations.	F 281		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to remove facial hair for 1 of 3 sample residents that required total assistance with activities of daily living (Resident #28). The Findings included: Resident #28 admitted on 1/4/08. The diagnoses included multiple sclerosis, diabetes and	F 312	1. Resident affected a.The Certified Nursing Assistant shaved resident # 28 facial hair on 4/6/2017, and the CNA was re-educated on ADL care. 2.Residents with potential to be affected a.Licensed Nurses checked all residents	5/5/17

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F 312	Continued From page 20 dementia. The quarterly Minimum Data Set (MDS) assessment dated 1/23/17, indicated Resident #28 ' s cognition was moderately impaired and she required total assistance with activities of daily. The care plan dated 2/1/17 revealed Resident #28 had a problem of self-care deficit with activities of daily living and that he/she was totally dependent on staff for all activities of daily living (ADLS.) The goal included the resident needs would be met by staff, she would be kept clean, dry, properly dressed and odor free. The interventions included the removal of facial hair as needed unless otherwise requested, shower as scheduled, explain procedures to her prior to touching and give her time to attempt to express herself. During an observation on 4/4/17 at 5:10 PM, Resident #28 was lying in bed in bed, there was long facial hair on the upper lip and chin, longer than an inch. During a follow-up observation/interview on 4/5/17 at 9:38 AM, Resident #28 was lying in bed and the long facial hair on her upper lip and chin had not been removed. Resident #28 stated staff did not offer to remove the facial hair during her shower or bath. During a meal observation on 4/5/17 at 12:20 PM, Resident #28 was taken to the dining room for her meal. The facial hair remained unshaven. During an observation on 4/5/17 at 3:30 PM, Resident #28 was seated in the hall and the facial hair had not been removed. During an observation/interview on 4/6/17 at	F 312	on 4/6/2017 for facial hair, grooming was provided as needed by CNAs and Nurses. 3.Systemic Changes. a.On 4/19/2017 the Director of Nursing and the Clinical Competency Coordinator initiated 100% in-service for all Certified Nursing Assistance and Licensed Nursing regarding providing ADL care with emphasis on removing unwanted facial hair. Licensed Nurses and Certified Nursing Assistants not educated by 5/4/2017 will be removed from the schedule until their education is complete. For new CNAs and Licensed Nurses, education on ADL care to include grooming will be provided during new hire orientation. b.An audit tool was implemented for ADL care to include grooming to be used by floor nurses. Refusals will be care planned. Nurse Managers/Unit Managers will validate the ADL care audit tool for completion daily for 7 days then weekly for 3 weeks, then monthly for 3 months. 4.Monitoring a.The Nurse Managers/Unit Managers will present any findings to the DON. The Director of Nursing will present any issues with non-compliance to the Quality Assurance and Performance Improvement committee monthly for 3 months to ensure compliance.	

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8:30AM, Resident #28 was lying in bed and the facial hair remained in the same condition. She stated she was given a bed bath the day before, but the staff did not shave her facial hair. "It would be nice if they would remove it and I should not have to remind them, I thought it was part of them cleaning me up."

Review of Resident #28 ' s shower schedule revealed her shower days were Monday, Wednesday and Friday. The form indicated whether facial hairs were shaven or not. On Monday, April 3, 2017, it was documented that Resident #28 received a bed bath and the facial hair had not been removed. On Wednesday, April 5, 2017, it was documented during shower the facial hair had been removed.

During an observation/interview on 4/6/17 at 9:42 AM, NA #5 indicated the residents should be shaven when a shower or bath was given. She stated the responsible person would document on the shower sheet each day when it was completed. NA#5 observed the condition of the resident's face and confirmed the facial hair was very long. She indicated the assigned NA for the scheduled shower day was responsible for the removal of the hair.

During an interview on 4/6/17 at 10:01 AM, Nurse #6 indicated the unit manager was responsible for ensuring that nursing assistants were completing the task on the shower schedule form. She indicated that if a resident refused a shower staff should document the refusal on the form. Nurse #6 observed the condition of Resident#28 ' s face and confirmed the resident ' s facial had not been removed. Nurse #6 also reviewed Resident #28 ' s shower schedule and confirmed the document

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F 312	Continued From page 22 was inaccurate and that the NA documented the resident ' s facial hair had been removed when it was not done. During an interview on 4/6/17 at 3:33 PM, NA #6 stated the removal of facial hair was part of the activities of daily living process during scheduled shower/bath days. The NA#6 confirmed she had not removed the facial hair from Resident #28 as documented on the scheduled shower form.	F 312		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (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. (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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide restorative nursing care for contracture management for 4 of 4 residents (Resident #55, #36, #92, # 160), reviewed for splint application. Findings included: 1. Resident number #92 was admitted to the facility on 7/9/14 with diagnoses, in part, of	F 318	1.Resident affected a.On 4/6/2017 Physician orders for residents # 55, #36, #160, and #92 were clarified and therapy referral made for contracture management. 2.Residents with Potential to be affected. On 4/18/2017 all residents were screened by the Licensed Nurses for contractures	5/5/17

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F 318	Continued From page 23 diabetes mellitus, hemiparesis and left sided weakness. Review of the most recent care plan dated 10/7/16, revealed Resident #92 was at risk for skin impairment related to diabetes mellitus, decreased mobility and incontinence, [sic] use of splints. The most recent quarterly Minimum Data Set (MDS) dated 1/2/17, revealed moderate cognitive impairment and upper and lower extremity range of motion impairment on one side. There was no documented splint application, or therapy. Record Review of the care guide book [no date] revealed there was no "C.N.A Care Interventions Record Form" (A form used to guide nurse aides in daily resident care) available for review. Record review of the physician orders for the months of March and April revealed no physician order for splinting to the left extremity. Review of the March and April 2017 medication administration record (MAR) and treatment administration record (TAR) revealed no documentation of splint application. A therapy note dated 03/06/17, "Restorative training provided to restorative staff on splint application and positioning of LUE (left upper extremity) with a pillow for optimal positioning at all times, Staff verbalized understanding. Patient tolerated soft left posey [sic] elbow splint [a sling] and bladder forearm splint [A fore arm splint that wraps between the thumb and index finger that can be inflated to custom fit the patient] and was applied x 6 hours this date, without redness or skin integrity issues at elbow." A rehabilitation discharge order dated 03/07/17 documented, "Training completed with restorative aide on splint wear and nursing staff with wheel chair positioning." On 4/5/17 at 10:40 AM, the Unit Manager	F 318	and referrals were made to therapy for contracture management as needed. 3.Systemic Changes. a.The Director of Nursing and the Clinical Competency Coordinator began education on 4/7/2017 for the Licensed Nurses and Certified Nursing Assistant on application of splint and documentation of splints. Licensed Nurses and Certified Nursing Assistants not educated by 5/4/2017 will be removed from the schedule until their education is complete. Education on application and documentation of splints for new CNAs and Licensed Nurses will be provided during new hire orientation. b.Therapy Orders and/or physician orders for splinting are implemented by the licensed nurses, transcribed to the medication administration record and monitored for compliance. c.Licensed Nurses observe the splint/brace on the resident as ordered by the physician and/or therapy referral and document on the Medication Administration record compliance. Nursing staff is responsible for application and removal of splints as ordered by the physician and/or therapy. d.The Nurse Mangers/Unit Managers will oversee the restorative aides for compliance with therapy recommendations. e.The Assistant Director of Nursing and/or	

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F 318	Continued From page 24 indicated the nurse aides were expected to know their care plan/assignment at the beginning of the shift. The nurse aide should clarify their assignments with the floor nurse. Observation revealed on 4/5/17 at 11:48 AM, Resident #92 had no splint on her left elbow or arm. On 4/5/17 at 4:38 pm, the Therapy Director indicated resident number # 92 received splinting to her left upper extremity. Botox injections were administered to the hand to relax the muscle and made it possible to splint the hand. The Therapy Director reviewed the therapy note dated 3/6/17 and indicated the therapy department had trained the restorative aid to splint the left hand. The bladder splint caused no pressure to the pressure ulcer on her left thumb. It was scheduled to be placed for 6-8 hours a day. It was the restorative aide's responsibility to place the splint once the resident was discharged from the therapy program. On 4/6/17 at 9:30 AM, observation revealed Resident #92 had no splint applied to the left hand or arm. During an interview on 04/06/2017 at 9:31 AM, Nurse Aide# 2 indicated Resident #92 used to wear splints on her feet and that she was not sure about what splinting was currently ordered. She indicated that therapy trained the nursing staff (aides/nurses) how to apply and remove splints and documentation was in the computer. She reviewed the current restorative patient list and indicated Resident #92 had not received splinting by restorative. On 04/06/2017 9:35 AM wound care consultant indicated splinting to the left hand was reasonable as long as the pressure ulcer to the thumb was not affected. The wound care nurse stated he assumed the splint had been discontinued.	F 318	Nurse Managers will use the appliance application audit tool for compliance of the splints application and removal daily for 7 days, weekly for 3 weeks then monthly for 3 months. 4.Monitoring a.The findings on the appliance application tool will be presented to the Director of Nursing. The Director of Nursing will present any non-compliance issues to the Quality Assurance and Performance Improvement committee for review and recommendations monthly for 3 months to ensure compliance.	

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On 04/06/2017 at 3:20 PM, Restorative Aide #1 indicated Resident #92 wasn't on the restorative program. He stated he had no recollection of splint application for her and that splinting was discontinued when a physician order was written.
On 04/07/2017 at 10:05 AM, the MDS Nurse indicated to her knowledge the restorative aide documented in the computer when a splint was applied. She reviewed the computer documentation and indicated Resident #92 had no documented splints since 03/06/17, when the rehabilitation had ordered the splints to be applied by the restorative aid.
On 04/07/2017 at 10:24 AM, observation of the Resident #92 revealed the resident did not have the forearm bladder splint applied a sling was observed to the elbow.
On 04/07/2017 at 10:24 AM, Nurse Aide #5 indicated Resident #92 had a left forearm splint. Her splints were applied by the restorative aide. It was applied during the day and removed in the evening by the restorative aide.
On 04/07/2017 at 10:34 AM, Nurse #8, indicated Resident #92 received Botox injections to her contracted hand which really helped to open up her hand. The hand splint was applied by the restorative aide. When any resident had splints, the therapy department trained both the aides and restorative aide to apply splints. She was not sure if splinting was documented or not by the aides.
On 04/07/2017 at 10:53AM, Nurse #9 indicated splints were applied by the aides or the restorative aide. The restorative aide had a list of patients. Physical therapy determined the splint order and if the restorative aide or the floor aide applied the splint. The floor nurse checked that the splint was applied and recorded it on the MAR. There was no nurse who was responsible

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for the restorative program. All aides recorded the splint application in the computer. Splinting continued until discontinued by a physician order.

The Director of Nursing was not available for interview on 04/07/2017 at 1:14 PM or prior to exit at 3:00PM.

2. Resident #36 was admitted on 4/30/16. Review of his recent quarterly Minimum Data Set (MDS) assessment, dated 1/30/17, revealed resident ' s severe cognitive impairment. His diagnoses included left side hemiparesis (weakness) with left side upper extremity range of motion impairment. The MDS assessment of 1/30/17 did not indicate the splint application.

Review of Resident 36 ' s plan of care dated 1/18/17, revealed activity of daily living self-care performance deficit, related to hemiparesis. The approach was to provide therapy, including restorative devices as ordered.

Record review of the discharge occupational therapy notes dated 8/30/16, revealed that Resident #36 received left hand carrot splint up to eight hours daily. The Therapy Department trained nursing staff to apply a carrot splint to the left hand up to eight hours per day every day.

Record review of Resident 36 ' s aides care plan revealed left hand carrot splint application daily.

Review of Resident 36 ' s computerized daily aides report for March - April 2017 revealed that no splint applications were documented.

Review of Resident 36 ' s Medication Administration Record for April 2017 revealed no

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splint application.

On 4/4/17 at 9:35 AM, during an observation, Resident #36 was in wheelchair, well dressed and groomed. He did not have splint to his left hand.

On 4/4/17 at 10:15 AM, during an observation, Nurse Aide #3 was unable to find the splint in Resident #36 ' s room.

On 4/4/17 at 10:20 AM, during an observation, Restorative Aide #1 could not find the splint in Resident 36 ' s room.

On 4/4/17 at 10:25 AM, during an interview Restorative Aide #1 indicated Resident #36 was not on his list for splint application.

On 4/4/17 at 10:30 AM, during an interview Nurse Aide #3 indicated that she did not check the aide ' s care plan/assignment and did not provide the splint application for Resident #36.

On 4/5/17 at 10:35 AM, during an observation Resident #36 was sitting in his wheelchair. He had no splint to his left hand.

On 4/5/17 at 10:40 AM, during an interview, the Unit Manager expected that all the nurse aides to know aide ' s care plan/assignment at the beginning of the shift. The nurse aide could clarify it with the floor nurse.

On 4/6/17 at 8:35 AM, during an observation, Resident #36 was in wheelchair. He did not have splint to his left hand.

On 4/6/17 at 9:25 AM, during an observation/interview, Resident #36 was in

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wheelchair. He did not have splint to his left hand.

On 4/6/17 at 9:37 AM, during an observation, Nurse Aide #4 provided care for Resident # 36, did not apply splint and left the room.

On 4/6/17 at 9:39 AM, during an interview, Nurse Aide #4 indicated that Resident #36 did not require splint to his hand. Aide # 4 indicated she had not looked at the resident care plan. The Nurse Aide #4 reviewed the care plan and indicated that the left hand splint was applied daily. She confirmed that she did not know. Nurse Aide #4 obtained the carrot splint and did not know to which hand to apply the splint.

On 4/6/17 at 9:45 AM during an interview, the Rehabilitation Director indicated Resident # 36 received therapy services and was discharge on 8/30/16. The Therapy Department trained nursing staff to apply a carrot splint to the left hand splint daily up to eight hours per day.

On 4/7/17 at 10:10 AM, during an interview, the Corporate Nurse Consultant and the Administrator, indicated that they expected the staff on the floor to receive training to maintain splinting as ordered after resident ' s discharge from the Therapy Department.
3. Resident admitted on 2/1/16. The diagnoses included cerebral vascular accident and left side hemiplegia.

Review of the physician ' s order and restorative therapy referral, dated 10/14/16, revealed Resident #160 was to wear the left elbow/hand splint daily for 6 hours for left hand range of motion limitation

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Review of the Restorative Therapy Referral, dated 10/18/16, revealed the elbow splint/resting hand splint. The goals for restorative program were to complete gentle passive range of motion (PROM) to the left hand wrist and fingers. Then put left resting hand splint. Resident would tolerate resting hand splint for at least 4 hours daily. Complete gentle PROM to elbow and shoulder in all planes, then put left elbow splint. Resident will tolerate splint for at least 4 hours daily 6 times a week.

The Minimum Data Set (MDS) assessment, dated 1/10/17, indicated the resident required total care with activities of daily living. Resident 160 ' s cognition was intact. The MDS coded that resident had joint contracture.

Review of the care plan, dated 1/24/17, identified the problem as self-care deficits with activities of daily living (ADL ' s), related to cerebral vascular accident with hemiplegia, impaired mobility and general weakness. He required extensive to total assistance with ADLs. The goal included the resident ' s need would be met by staff. The resident would be kept clean, dry, properly dressed and odor free. The interventions included showers per schedule, nail care, physical and occupational therapy (PT/OT) as ordered and encouragement for him to participate in ADLS. There was no documentation of contracture or splint application on the care plan.

Review of the occupational evaluation, dated 1/26/17, revealed the resident was referred to therapy due to performance deficits, activities of daily living, limitation in range of motion of upper and lower extremities. Staff reported the resident tolerated left elbow extension splint and resting

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hand splint 6-8 hours daily after passive range of motion (PROM).

During an observation on 4/5/17 at 9:12 AM, in Resident160 ' s room there was a blue elbow/hand splint lying on the night stand.

During an interview on 4/5/17 at 9:12 AM, Resident #160 stated the staff did not apply the splint on a regular basis.

During an observation on 4/5/17 at 2:33 PM, Resident #160 was lying in bed without splint on.

During an interview on 4/5/17 at 3:45 PM, the restorative aide (RA) stated that for all the resident ' s involved in the restorative program, the splints were applied 6 days a week. The RA stated he was unaware of the occupational evaluation dated 1/26/17, that revealed Resident #160 was to wear the splint 6-8 hours daily. RA stated there was no set time for splints to be applied or removed for Resident #160.

During an observation on 4/5/17 at 4:42 PM, Resident #160 was lying in bed without splint.

During an interview on 4/6/17 at 9:36 AM, the MDS nurse indicated on the annual MDS, dated 1/10/17, Resident #160 was coded for range of motion (ROM) and splint /brace application. She was unaware of who was responsible for updating the care plan.

During an observation/interview on 4/6/17 at 9:50 AM, the splint was lying on the night stand. Resident #160 stated most of the time it is on the night stand if they remember to put it on.

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During an interview on 4/6/17 at 11:45 AM, the Director of Nursing (DON) stated she was unaware of the occupational evaluation dated 1/26/17 recommendation for daily splint application for Resident #160.

During an interview on 4/6/17 at 11:50AM, the Administrator indicated the expectation was that residents should wear splints in accordance to physician's order, the care plan should be updated and reflected the frequency for splint application and staff responsible. He added that if there were changes in residents ' condition, they should be re-evaluated by therapy.

4. Resident #55 was admitted to the facility on 12/29/15 with a readmission date of 7/14/16. Diagnoses included, in part, stroke with right side weakness and contractures to upper extremities.

The Minimum Data Set annual assessment dated 1/10/17 indicated Resident #55 was cognitively intact. Resident #55 required extensive assist with all activities of daily living (ADLs) except eating. She had impairments to upper and lower extremities bilaterally, used a wheelchair and was not coded as having splints, however was coded as having occupational therapy for 120 hours.

A review of the care plans revealed Resident #55 had a plan of care dated 7/14/16 to include self-care deficit with ADLs related to total immobility and severe contractions of all extremities. There were no specific interventions or goals for splints. An additional care plan updated on 1/24/17 for potential for discomfort or pain related to history of stroke, contractures and

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immobility. There was no specific care plans or interventions regarding the application of splints to the upper extremities.

An observation of Resident #55 on 4/3/17 at 2:30 pm revealed an alert and oriented resident lying in bed with bilateral hand contractures. There were no splints on the resident ' s hands at this time. The hand splints were observed on an outside shelf on top of the resident ' s closet.

An interview with Nurse #10 on 4/3/17 at 2:45 pm was conducted. Nurse #10 reported the resident did not wear hand splints.

An observation of Resident #55 on 4/3/17 at 3:45 pm revealed there were no splints on the resident at this time. There were splints observed on an outside shelf on top of the resident ' s closet.

A review of the restorative therapy referral dated 1/25/17 revealed the resident was on a program to wear a left resting hand splint, left elbow splint and T bar (splint with a "t" shape across the hand) splint to right hand for 4 to 6 hours daily.

A review of the current restorative aid log revealed the resident ' s name was assigned on this log to receive range of motion and splinting. The splinting included to apply left splint to elbow and left resting hand splint as well as a right hand splint.

A review of the February, March and April 2017 medication administration record (MAR) and treatment administration record (TAR) revealed there was no documentation of splint application.

An observation of Resident #55 on 4/4/17 at 9:18

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am revealed there were no hand splints applied to her right hand or left elbow and hand. The splints were observed on an outside shelf on top of the resident ' s closet.

An interview was conducted with Resident #55 on 4/4/17 at 12:56 pm. The resident revealed she was supposed to wear splints to her hands but no one has put them on her for a long time. The resident pointed to the top shelf of her closet and stated "they are up there." The resident could not remember the last time the splints were applied. The resident reported she did not mind wearing them and stated they were helping a lot. The resident reported she did not refuse to wear them, but she had not been asked by staff to put them on.

An interview with the Rehab Director (RD) on 4/4/17 at 11:30 am revealed the resident was being followed by Occupational Therapy (OT) up until 2/8/17 for splinting and was doing very well. The RD reported she was wearing her splints for 6-8 hours per day and tolerating them well. The RD reported when OT made the decision to discontinue therapy and refer to the resident to restorative, an order was written and education was provided to the Restorative Aide/Nursing department to teach them the proper way to apply the splints.

An observation of Resident #55 on 4/4/17 at 12:58 pm revealed there were no hand splints applied to her right hand or left elbow and hand. Both hands were noted to be contracted. Three of her fingers on the left hand were folded in toward her palm and her thumb rested on her middle finger. The index finger was bent but not all the way toward her palm. The right hand was

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noted to have all three fingers folded into her palm and her index finger crossed over onto the middle finger. The resident had her lunch tray in front of her at this time and was using her left hand to eat.

A review of the Occupational Therapy (OT) notes revealed Resident #55 was discharged from OT and was to start restorative care for splint application to left elbow and hand and right hand effective 2/8/17.

A review of Resident #55 ' s care guide revealed there were no instructions for the application of splints to the upper extremities.

An interview was conducted with NA #1 on 4/5/17 at 3:00 pm. The NA reported Resident #55 wore bilateral hand splints. The NA reported she did not apply the splints, the restorative aide applied them. NA #1 reported each resident had a care guide. The NA reported the care guide provided instructions on how to take care of each resident. NA #1 confirmed the care guide was not updated to include the left and right hand splints for Resident #55.

An interview was conducted with Nurse #2 on 4/5/17 at 3:15 pm. Nurse #2 reported Resident #55 had bilateral hand contractures and she wore splints. Nurse #2 reported she did not put the splints on the resident and that she believed they were applied by the restorative staff.

A review of the restorative report roster for Resident #55 revealed the hand splints were applied 16 days since February 8, 2017.

An interview was conducted with Restorative Aide

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F 318	Continued From page 35 (RA) on 4/6/17 at 3:05 pm. The RA confirmed the resident had an order to apply bilateral hand splints daily. The RA reviewed the documentation from the restorative roster but was unable to indicate why the splints were not documented as applied daily. The RA reported the resident tolerated the splints well and was supposed to wear them 6 - 8 hours daily. The RA reported he did not apply the splints on this day. The RA was unable to locate the splints. An interview was conducted with the Director of Nursing (DON) on 4/6/17 at 11:45 am and revealed that her expectation was for staff to follow written orders as prescribed.	F 318		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, physician assistant and physician interviews, the facility failed to administer antibiotic (Oxacillin) as ordered over a period of four days for 1 of 4 sampled residents, reviewed for medication (Resident #253). Findings included: Resident #253 was admitted on 3/31/17. Her diagnoses included left leg wound infection. There was no Minimum Data Set assessment	F 333	1.Resident affected a.An alternate IV antibiotic was ordered by the physician on 4/4/2017, and administered the same day for resident # 253. The resident was discharged home on 4/19/2017 as planned. 2.Residents with potential to be affected. a.All other residents with IV antibiotics orders were reviewed and the antibiotics	5/5/17

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F 333	Continued From page 36 available for review. The admission assessment indicated resident ' s intact cognition and presence of the left leg wound with dressing. Review of hospital ' s discharge documents, dated 3/31/17, revealed Resident #253 was diagnosed with MSSA (methicillin susceptible staphylococcus aureus) infection of her left leg stump (above knee amputation) wound and the discharge order indicated Oxacillin (antibiotic) 2 g (gram) in 0.9% (percent) sodium chloride solution 100 ml (milliliter) IV (intravenously) every 4 hours for 12 days. Review of Resident 253 ' s physician ' s order, dated 3/31/17, revealed the order for Oxacillin 2 g in 0.9% sodium chloride solution 100 ml IV every 4 hours for 12 days. Review of Resident 253 ' s interim plan of care, dated 3/31/17, revealed the resident was admitted with the left leg wound infection to continue the treatment with medication administration according to physician ' s order. Record review of Resident 253 ' s nurses ' notes, dated 4/2/17, revealed the staff received information from pharmacy that after two attempts to obtain Oxacillin on 3/31/17 and 4/1/17, it was not available due to shortage of this medication. On 4/1/17 the pharmacy technician recommended to notify the physician to request the alternative medication. Review of Resident 253 ' s physician ' s order, dated 4/4/17, revealed the order to discontinue Oxacillin and start the Cefazolin (antibiotic) 1 g with 50 ml of normal saline solution IV every 12 hours for 14 days.	F 333	were available in the facility for administration as ordered. b.For residents with IV antibiotics on admission the process of securing the medication is: Physician orders are faxed to pharmacy, if the medication in unavailable from pharmacy then the charge nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will contact the physician immediately for an alternative order prior to the next scheduled dose. 3.Systemic Changes a.Licensed Nurse Education began on 4/7/2017 by the Clinical Competency Coordinator and Director of Nursing on Procuring medications and immediate Physician notification if the medication is unavailable. Licensed Nurses not educated by 5/4/2017 will be removed from the schedule until their education is complete. b.New licensed nurses will be educated on procuring medications and immediate physician notification if medication is unavailable during new hire orientation. c.Upon admission the Physician orders are faxed to pharmacy, if the medication is unavailable from pharmacy the nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will contact the physician immediately and obtain	

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F 333	Continued From page 37 Review of Resident 253 ' s Medication Administration Record (MAR) for March and April 2017 revealed Oxacillin was not marked as administered between 3/31/17 and 4/3/17. On 4/4/17 at 9:00 PM, the MAR indicated the resident received Cefazolin 1 g with 50 ml normal saline solution IV. Record review of the nurses ' notes, dated 4/4/17 on third shift, revealed that Resident #253 received first dose of antibiotic Cefazolin. Review of the pharmacy communication form, dated 4/5/17, revealed that Oxacillin was not available and Cefazolin recommended. On 4/5/17 at 8:10 AM, during the observation/interview, Resident #253 was in her room with isolation precautions. The resident was alert and oriented to self, place, time and indicated she had received an antibiotic on 03/31/17 in hospital and not again until 4/4/17. On 4/5/17 at 8:20 AM, during an interview, Nurse #4 indicated that she was aware Resident #253 had an order for Oxacillin but did not receive it because it was not available on 4/3/17. The nurse indicated the unit manager and physician were notified on 4/3/17 and that she did not try to obtain Oxacillin. On 4/5/17 at 8:30 AM, during an interview, Nurse #1 indicated that on 3/31/17 she sent a fax with Resident 253 ' s medications request to the pharmacy and transcribed all the orders from the hospital discharge documents, including Oxacillin, to the MAR. She stated that she saw the new order for Cefazolin on 4/4/17.	F 333	alternate order prior to the next scheduled dose. d.The floor nurses will utilize the medication availability audit tool to validate that the medication is available in the facility. The Nurse Managers/Unit Managers will review the audit tool to ensure availability of medications. This will be done daily for 7 days, weekly X3 weeks and then monthly for 3 months. The DON, ADON and Nurse Managers will monitor for compliance. 4.Monitoring a.The Nurse Managers/Unit Managers will report any findings to the Director of Nursing. The Director of Nursing will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance.	

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On 4/5/17 at 9:10 AM, during an interview, the Physician Assistant (PA), indicated that she worked Monday through Friday and there was physician on call available during weekend. She expected the staff to notify physician on call in regards to unavailable medications. The PA added that lack of antibacterial therapy could delay the wound healing.

On 4/5/17 at 9:20 AM, during an interview, the Assistant Director of Nursing indicated she expected the staff to communicate with physician on call if the physician ' s order could not be completed.

On 4/5/17 at 9:30 AM, during an interview, the Physician indicated that on 3/31/17 he approved the Oxacillin order for Resident #253 at her admission. He was not on call during the weekend and did not know the resident did not receive antibiotic. The Physician was notified about this situation on Monday, 4/3/17, and he stated he communicated with hospital clinic to choose better antibiotic and ordered Cefazolin on 4/4/17. He stated that interruption in antibacterial treatment could delay of resident ' s wound healing.

On 4/5/17 at 3:30 PM, during an interview, Nurse #8 indicated that he remembered Resident 253 ' s admission on 3/31/17. He communicated with the physician to approve all the orders. On 3/31/17 at 6 PM he called the pharmacy in regards to a missing dose of Oxacillin and was told that it was not available from the main pharmacy. The nurse communicated with pharmacy technician several times and received information that Oxacillin was not available due to nationwide shortage. The nurse did not call the

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F 333	Continued From page 39 physician on call to report the issue. He completed the communication to physician book to request alternative medications. The nurse passed the information that the Oxacillin was not administered to the next shift staff. On 4/5/17 at 3:40 PM, during an interview, Nurse #5 indicated that she worked on 3/31/17 and recalled that Nurse #8 communicated to the pharmacy several times in regards to medications for Resident #253, but she was not involved in that situation. She worked with the resident on 4/1/17, 4/2/17 and remembered that the Oxacillin was not available for administration. Nurse #5 notified the Weekend Supervisor on 4/1/17 and did not call to notify the physician on call. On 4/5/17 at 3:50 PM, during an interview, the Weekend Supervisor indicated that she worked as Weekend Nurse Supervisor for the entire building from 3/31/17 to 4/2/17. She could recall that Nurse #8 communicated with the pharmacy, but nobody brought to her attention that Resident #253 did not receive the antibiotic. The Nurse Supervisor did not know that the Nurse #8 completed the communication book and did not talk to the physician on call. She expected the staff during weekend to notify by phone the physician on call about unavailable medication and to ask for alternative medication.	F 333		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 371		5/5/17

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F 371	Continued From page 40 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to: label and date food items 3 refrigerators; failed to clean equipment in two satellite kitchens; failed to clean a plate warmer, an oven, storage containers, two carts for dishes and trays; and failed to clean sticky floor under the steam table. The findings included: a. On 4/3/17 at 10:12 AM, during the tour of the satellite kitchen and resident refrigerator on the 1st and 2nd floor, the refrigerators had 2 zip lock plastic bags of unlabeled/undated parsley, an unlabeled/undated roasted chicken, a vegetable/fruit tray unlabeled/undated and 2 containers of opened ice cream unlabeled/undated.	F 371	Corrective action: On 4/3/2017 all food items not labelled and/or dated from 3 refrigerators were removed and disposed of. The cleaning of equipment in two satellite kitchens, plate warmer, oven, storage containers, clear containers, Storage cart, trays, pans and dishes, two carts for dishes and trays, microwaves on 1st & 2nd floor, steam tables on 1st & 2nd floor plus the surrounding surfaces, exhaust fans in 1st & 2nd floor kitchens, and floor under the steam table was initiated on 4/3/2017 and completed on 4/7/2017. Corrective action will be accomplished by 5/3/2017 for those residents to be affected by the same deficient practice.	

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F 371	Continued From page 41 On 4/3/17 at 10:12 AM, during an interview, the Dietary Manager (DM) stated that items should have been labeled and dated prior to being placed in the refrigerator. On 4/3/17 at 12:20PM, during an interview, the Dietary Aide (DA #1) stated items should be labeled/dated prior to putting items in the refrigerator. On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist. The checklist included label/date food items prior to putting them in the refrigerator. On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The food should be labeled/dated prior to putting items into the refrigerator. b. On 4/3/17/17 at 10:12 AM, during the observation of the satellite kitchens on the 1st and 2nd floor, the microwaves were dirty with large volumes of dried food, liquids on the inside and outside. The steam tables were dirty with leftover food in standing water on the inside of the steam table. The top and surrounding surfaces was dirty and had large volumes of dried foods and liquids. On 4/3/17 at 10:12 AM, the DM stated the dietary aides were responsible for cleaning all the kitchen equipment, surfaces of the microwave and steam table after each meal in accordance of the kitchen checklist.	F 371	Systematic changes put in place to ensure the deficient practice does not occur. 100% in-service for all dietary staff on labelling and dating food items, sanitation to include cleaning equipment and the floor was completed on 4/7/2017. Employees on leave of absence from work will be in-serviced upon return before they are allowed to work. All new employees/hires will be educated on the expectation during orientation. Food items will be dated upon opening and dietary staff will check daily and dispose of any outdated food items from the refrigerators and other food storage areas. The Certified Dietary Manager (CDM)/Assistant Dietary Manager and/or the designated supervisor will review 5x a week for 4 weeks and thereafter 2x a week for 3 months to maintain compliance. The floor will be cleaned twice daily and/or as needed by the designated dietary staff. Kitchen equipment will be cleaned at the end of every shift by dietary staff. Food tray carts will be power-washed once every week and/or as needed. The cleaning schedule has been posted for staff. The Dietary Manager, Assistant Manager or the designated supervisor will review 4 days a week for 4 weeks and thereafter weekly for 3 months to maintain compliance. Housekeeping will clean and strip the kitchen floor once a month and the Administrator will review for	

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F 371	Continued From page 42 On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist. The checklist included cleaning the refrigerators, steam tables and microwave. On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist. The checklist included cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen. Review of the daily cleaning assignment the equipment was to be cleaned daily. On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist. The kitchen equipment should have been cleaned. c. On 4/3/17 at 10:12 AM, during the observation of the satellite kitchens on the 1st and 2nd floor, the exhaust fan over the steam table had a large volume of gray dust blowing over the steam table. On 4/3/17 at 10:12AM AM, during an interview, the DM stated maintenance was responsible for cleaning the fan and she would contact maintenance to clean the fan. DM indicated the fan should not have been blowing dust over the steam table with open food. On 4/3/17 at 12:30 PM, the lunch meal was being served and the fan was blowing dust.	F 371	compliance. An audit tool will be initiated for use by the Dietary Manager, Assistant Dietary Manager and/or the designated supervisor for any issues of non-compliance. The Administrator will review the audit tool weekly and present any findings of non-compliance to the QA committee monthly x3 months.	

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d. On 4/3/17 at 10:25 AM, during the observation, the kitchen the plate warmer in the main kitchen had large volumes of dried foods and liquids on the inside and outside.

On 4/3/17 at 10:25 AM, during an interview, the Dietary Manager (DM) stated the kitchen staff was responsible for cleaning all kitchen equipment in accordance to the kitchen checklist.

On 4/3/17 at 12:20 PM, during an interview, Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist. The checklist included cleaning the refrigerators, steam tables, microwaves and plate warmer. Review of the daily cleaning assignment the equipment was to be cleaned daily.

On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist. The checklist included cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen.

On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist. Review of the daily cleaning assignment the equipment was to bed cleaned daily.

e. On 4/3/17 at 10:25AM, the dry storage

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containers that contained the flour and sugar was stored under the steam table. The containers were very dirty with dried food and liquids on the inside and outside.

On 4/3/17 at 10:25 AM, during an interview, the Dietary Manager (DM) kitchen staff responsible for cleaning the containers in accordance to the kitchen checklist.

On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist. Review of the daily cleaning assignment the equipment was to bed cleaned daily.

f. On 4/3/17 at 10:25AM, the oven had a heavy grease build up and large volumes of dried food and liquids on the inside and outside.

On 4/3/17 at 10:25 AM, during an interview, the Dietary Manager (DM) staff was responsible for cleaning all kitchen equipment in accordance to the kitchen checklist. Review of the daily cleaning assignment the equipment was to be cleaned daily.

On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist.

On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was

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responsible for following the kitchen checklist. The checklist included cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen.

On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The food should be labeled/dated, the dry storage containers cleaned and wiped down daily, dishes, pans and utensils should be thoroughly cleaned/dried and stacked properly on the dry storage shelves. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist.

g. On 4/3/17 at 10:25 AM, there were 4 large clear containers stored on the dry storage rack that had a large volume of dried foods and liquids on the inside and around the edges of the container.

On 4/3/17 at 10:12 AM, during an interview, the Dietary Manager (DM) staff was responsible for cleaning all kitchen items in accordance to the kitchen checklist. Review of the daily cleaning assignment the equipment was to be cleaned daily.
On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist.

On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist.

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The checklist included label/date food items prior to putting them in refrigerator, cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen.

On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The dry storage containers cleaned and wiped down daily, dishes, pans and utensils should be thoroughly cleaned/dried and stacked properly on the dry storage shelves. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist.

h. On 4/3/176 at 10:25 AM, the storage cart for clean dishes and 9 trays had a large volume of dried foods and liquids on the inside and outside. There were clean dishes and trays stacked on the cart.

On 4/3/17 at 10:25 AM, during an interview, the Dietary Manager (DM) stated the cart should be cleaned prior to stacking dishes or trays on them. The dietary staff was responsible for following the kitchen cleaning checklist.

On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist.

On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist.

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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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The checklist included cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen.

On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The dry storage containers cleaned and wiped down daily, dishes, pans and utensils should be thoroughly cleaned/dried and stacked properly on the dry storage shelves. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist

i. On 4/5/17 at 11:37 AM, there was 7 silver pans stacked wet with food grains inside and outside of the pans and 2 clear containers of utensils that had dirty brown liquids and food products inside and outside stored on the dry storage rack.

On 4/5/17 at 11:37 AM, during an interview, the DA#3 confirmed the expectation was to check all dished prior to stacking them on the dry storage and not to stack dishes wet on top of one another. DA#3 also confirmed the kitchen checklist was available and should be followed.

On 4/5/17 at 11:37 AM, during an interview, the DM indicated the expectation was for staff to check all the dishes, equipment for food prior to putting them on the dry storage rack. If the dishes was still dirty staff should return them to the dish machine.

On 4/6/17 at 3:00 PM, during an interview the

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Administrator indicated the DM and ADM was responsible for ensuring the main kitchen and satellite kitchens were clean and orderly after each shift in accordance with the current kitchen checklist.

j. On 4/3/17 at 10:25 AM, the floor under the steam table in the main kitchen was very sticky and had large volumes of dried foods, liquids and trash on the floor.
On 4/3/17 at 10:25 AM, during an interview, the Dietary Manager (DM) stated kitchen staff was responsible for cleaning all the kitchen equipment and remove trash from floor. Review of the daily cleaning assignment the equipment was to be cleaned daily.

On 4/3/17 at 12:20PM, during an interview, the Dietary Aide #1 stated the dietary staff was responsible for cleaning all the equipment in the satellite kitchens and main kitchen in accordance to the checklist. The check list. Review of the daily cleaning assignment the equipment was to be cleaned daily.
On 4/3/17 at 12:35 PM, during an interview, the Dietary Aide #2 stated the dietary staff was responsible for following the kitchen checklist. The checklist included cleaning all kitchen equipment in the main kitchen as well as the satellite kitchen.

On 4/5/17 at 11:42 AM, during an interview, the Assistant Dietary Manager/Cook stated that he and the DM was responsible for checking behind the dietary staff to make sure they were completing and following the kitchen checklist. The main kitchen and satellite kitchen equipment should be cleaned monthly in accordance to the monthly cleaning checklist.

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F 371	Continued From page 49 Review of the kitchen checklist identified the task that needed to be done daily, weekly and monthly. Staff were responsible for initialing when the assignment was completed. The DM reviewed the checklist and confirmed some task had not been documented as completed.	F 371		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident was seen by the attending physician once every 60 days for 1 of 2 residents receiving hospice services (Resident #141). The findings included: Resident #141 was admitted on 1/12/16. The diagnoses included Alzheimer ' s dementia, dysphagia, hypertension and depression. The significant change Minimum Data Set (MDS) assessment dated 1/9/17, indicated Resident #141 ' s cognition was impaired and she required total assistance with activities of daily living. Review of Resident #141 ' s physician progress note dated 12/31/16, revealed Resident #141 had	F 387	1.Immediate corrective action taken for this alleged deficient practice includes: a.The attending physician on 4/6/17 saw resident # 141. 2.Resident with potential to be affected. a.8 of 8 Hospice residents charts were reviewed, 5 of 8 resident required a physician visit in April 2017. 3.Measures put into place to assure that the alleged deficient practice does not recur include a.The Medical Records Coordinator was	5/5/17

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F 387	Continued From page 50 been treated for an infection by the physician assistant. There was no other physician progress note after this date. Review of the physician ' s order dated 1/2/17, revealed Resident #141 was placed on hospice care. During an interview on 4/6/17 at 10:40 AM, the Unit Manager and Nurse #6 indicated that once a resident was placed on hospice the facility physician or physician assistant would no longer handle the resident ' s care. Both the Unit Manager and Nurse #6 indicated the hospice nurse would handle the resident ' s care and the physician and/or physician assistant would be contacted by the hospice nurse, if there was an emergency and/or new orders needed to be obtained. The record was reviewed and both nurses confirmed there were no current notes from the physician and/or physician assistant since December 2016. During an interview on 4/6/17 at 10:45 AM, the Physician Assistant (PA) stated she had not seen or written a note on Resident #141 after she was transferred to hospice care. The PA note was written 12/31/16.The PA indicated that once a resident elected the hospice benefit, the facility nursing staff were supposed to contact the hospice nurse. The hospice nurse would handle the care and treatment and contact the primary physician or PA for orders or treatments that hospice could not handle. At that point if it was an emergency then the physician would come and assess the resident. During an interview on 4/6/17 at 10:57 AM, the Assistant Director of Nursing stated that once a	F 387	educated regarding required physician visits on 4/24/2017 by the Director of Nursing. b.The Medical Records Coordinator will maintain a scheduler for the Hospice Residents to maintain physician visit compliance. c.The Director of will review the Hospice resident scheduler and validate that the Attending physicians has seen the resident within the required 60 days. The Director of Nursing will validate this monthly. 4.Monitoring put in place to assure the alleged deficient practice does not recur includes: The Director of Health Services will present the findings of the Hospice Physician Visit review to the Quality Assurance Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance has been sustained.	

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F 387	Continued From page 51 resident was placed on hospice, the facility physician/PA would not see the resident unless it was an emergency. The facility nurse would contact the hospice nurse for assessment /evaluation and then hospice would contact the physician/PA for treatment. During a telephone interview on 4/6/17 at 12:47 PM, the Hospice Nurse stated that when a resident elected hospice, the charge nurse contacted the hospice nurse for assessment or evaluation. If the resident declined or there was an emergency, the hospice nurse contacted the facility physician for orders/treatments. The Hospice Nurse indicated the facility physician/PA would only see the resident on an as needed basis. During an interview on 4/6/17 at 1:16 PM, the Director of Nursing (DON) stated the facility physician was responsible to visit the residents every 60 days as required by regulation. The DON confirmed the physician ' s last visit was 12/31/16. During a follow-up interview on 4/6/17 at 2:54 PM, the administrator stated after discussion with management, the expectation was for the facility physician to see the resident in accordance to the regulation of every 60 days.	F 387		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		5/5/17

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F 520	Continued From page 52 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (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 (g)(2) The quality assessment and assurance committee must : (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 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility Quality Assessment and Assurance Committee failed to maintain implemented	F 520	Corrective action: On 4/3/2017 all food items not labelled and/or dated from 3 refrigerators were removed and disposed	

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F 520	Continued From page 53 procedures and monitor interventions the committee put into place on April of 2016. This was for one deficiency which was originally cited on April 1, 2016, on a recertification survey. The deficiency was in the area of food procure, store, sanitary condition. The continued failure of the facility during two federal surveys of record show a pattern of the facilities ' inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F371: Based on observation, staff interview and record review, the facility failed to: label and date food items 3 refrigerators; failed to clean equipment in two satellite kitchens; failed to clean a plate warmer, an oven, storage containers, two carts for dishes and trays; and failed to clean sticky floor under the steam table. The facility was originally cited for F371 for failing to label and date open nourishment items in April 2016. On 09/12/14 at 2:20 pm, during an interview, the Administrator indicated the Quality Assessment and Assurance Committee meetings occurred monthly. The Administrator acknowledged they had a repeat tag.	F 520	of. The cleaning of equipment in two satellite kitchens, plate warmer, oven, storage containers, clear containers, Storage cart, trays, pans and dishes, two carts for dishes and trays, microwaves on 1st & 2nd floor, steam tables on 1st & 2nd floor plus the surrounding surfaces, exhaust fans in 1st & 2nd floor kitchens, and floor under the steam table was initiated on 4/3/2017 and completed on 4/7/2017. Corrective action will be accomplished by 5/3/2017 for those residents to be affected by the same deficient practice. The QAA Committee met on 5/3/2017 to discuss the findings from the annual survey annual and the need to maintain compliance. Systematic changes put in place to ensure the deficient practice does not occur. 100% in-service for all dietary staff on labelling and dating food items, sanitation to include cleaning equipment and the floor was completed on 4/7/2017. Employees on leave of absence from work will be in-serviced upon return before they are allowed to work. All new employees/hires will be educated on the expectation during orientation. Food items will be dated upon opening and dietary staff will check daily and dispose of any outdated food items from the refrigerators and other food storage areas. The Certified Dietary Manager (CDM)/Assistant Dietary Manager and/or the designated supervisor will review 5x a	

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F 520	Continued From page 54	F 520	week for 4 weeks and thereafter 2x a week for 3 months to maintain compliance. The floor will be cleaned twice daily and/or as needed by the designated dietary staff. Kitchen equipment will be cleaned at the end of every shift by dietary staff. Food tray carts will be power-washed once every week and/or as needed. The cleaning schedule has been posted for staff. The Dietary Manager, Assistant Manager or the designated supervisor will review 4 days a week for 4 weeks and thereafter weekly for 3 months to maintain compliance. Housekeeping will clean and strip the kitchen floor once a month and the Administrator will review for compliance. An audit tool will be initiated for use by the Dietary Manager, Assistant Dietary Manager and/or the designated supervisor for any issues of non-compliance. The Administrator will review the audit tool weekly and present any findings of non-compliance to the QA committee monthly x3 months. Any findings and/or areas on non-compliance will be presented by the Administrator to QAA Committee monthly or as needed to ensure compliance.	