STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 04/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 166 SS=C	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		5/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2017

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's grievance policy failed to include the resident's right to file grievances anonymously and the contact information of the grievance official including their name, physical and e-mail business address and business phone number. Findings included: A review of the facility policy dated 2/2017 and titled "Truly Listening to Our Customers Program" was provided by the social worker (SW) on 4/28/17. The policy stated "The facility actively resolves concerns submitted orally or in writing to any member of the facility's staff. The Administrator acts as the Grievance Official. 1. If a resident, a resident's legal representative, or another interested person has a concern, a staff member should encourage and assist the resident, or person acting on the resident's behalf to file a written concern with the facility using the Concern Form. 2. If the facility receives a concern orally, staff should document the concern using the Concern Form. 3. Staff receiving the concern should acknowledge receipt of concern, immediately notify the Grievance Official and initiate an investigation. 4. If the concern may be	F 166	Please accept this Plan of Correction (POC) as Surry Community Health and Rehabilitation Center's credible allegation of compliance. Preparation and execution of this POC does not constitute admission or agreement with the findings of noncompliance. The POC is being provided pursuant to Federal ad State requirements which require an acceptable Plan of Correction as a condition of continued certification. F166 □ 483.10 Right to Prompt Efforts to Resolve Grievances 1. (a) Director of Nursing Services immediately made the Director of Policy Development & Communications Compliance and Regulatory Affairs aware that the required components effective November 2016 were not reflected in the facility grievance policy, specifically, the resident's right to file grievances anonymously. (b) A notice was immediately posted on the Family Board in the front lobby to notify residents, family, and staff of the contact information of the grievance official including their name, physical and	

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F 166	Continued From page 3	F 166		

resolved immediately, the staff, under the guidance of the Grievance Official, will resolve the concern and document the resolution on the Concern Form. 5. All other concerns are investigated and resolved within 72 hours from receipt of the concern.

The Grievance Official and the inter-disciplinary team will designate an investigator.

The investigator will have 2 days following receipt of the concern to complete the investigation, document his or her conclusions using the Concern Form, and forward the completed form to the Grievance Official.

Within 24 hours, the Grievance Official reviews the findings with the investigator and the inter-disciplinary team, as required, to determine a resolution. 6. The Grievance Official informs the individual filing the concern of the resolution as soon as possible but not longer than 72 hours after receipt of the concern. Upon request by a resident or a resident's legal representative, the Grievance Official will issue a concern decision using the Concern Decision Form. 7. The Grievance Official follows through with appropriate corrective action to resolve the concern. 8. The Grievance Official will follow up with the individual filing the concern within 7 days after the initial follow up to ensure that the concern is addressed to their satisfaction."

On 4/29/17 at 2:59 PM the SW was interviewed and stated there was a grievance/concern "policy" in the admissions packet that residents received when they entered the facility.

A review of the facility admissions packet

e-mail business address and business phone number.
2. (a) A notice was posted on the Family Board in the front lobby to notify residents, family, and staff of the resident's right to file a grievance anonymously. Maintenance will install a Concern Box near the Family Board in the front lobby for anonymous concerns. This will be checked daily Monday □ Friday by the Grievance Official or designee. A notice informing residents they have the right to file a grievance anonymously has been placed in each resident's room to ensure residents are aware of their right to file a grievance anonymously, as well as the location of the Concern Box.
(b) Grievance Official posting was placed on Family Board in front lobby. A copy of this posting was also placed in each resident's room, and a copy was mailed to each resident's responsible party. A copy of the Grievance Official Posting will also be given to Family Council President in a meeting on 05/17/2017.
3. (a) A copy of the notice was placed in each resident's room to ensure residents are aware of their right to file a grievance anonymously, as well as the location of the Concern Box. Staff will be re-educated on Facility Grievance Policy and notice stating residents have the right to file a grievance anonymously, the location of Concern Box near the Family Board in the front lobby for anonymous concerns. Random audits will be completed on 5 residents per hall (20 residents total) by Director of Nursing, Assistant Director of Nursing, or designee

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F 166	Continued From page 4 revealed information titled "Concerns and Issues" which stated, "It is the policy of the facility to support each resident's right to voice concerns and to ensure that after a concern has been received, the facility will actively resolve the issue and communicate the resolution's progress to the resident and/or resident's family in a timely manner. The Administrator is ultimately responsible for the resolution of all concerns and/or issues. Any resident, his or her representative, family member, employee, or appointed advocate may file a concern without fear of threat or reprisal in any form. All concerns and issues are investigated, resolved and documented." An interview with the Administrator on 4/29/17 at 3:00 PM revealed he was not aware that the required components effective November 2016 were not reflected in the facility grievance policy. He stated his expectation was that all the required information pertaining to grievances be included in the policy.	F 166	to ensure residents are aware of their right to file a grievance anonymously, and the location of the Concern Box weekly x 4 weeks, then monthly x 3, or until no further issues noted. (b) A copy of the Grievance Official posting will be placed in each resident's room. Staff will also be re-educated regarding the Grievance Official. Random weekly audits will be completed on 5 residents per hall by Director of Nursing, Assistant Director of Nursing, or designee to ensure residents are aware of who the Grievance Official is, and how to get in touch with him weekly x 4 weeks, then monthly x 3, or until no further issues noted. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	
F 244 SS=C	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 244		5/29/17

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F 244	Continued From page 5 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of Resident Council minutes, the facility failed to effectively communicate the facility's efforts to address concerns about nurse staffing which were voiced in the Resident Council meetings. Findings included: Resident #18 admitted to the facility 12/22/14 with diagnoses of chronic obstructive pulmonary disease, hypertension, generalized muscle weakness and hypothyroidism. An annual comprehensive minimum data set (MDS) assessment dated 1/24/17 revealed Resident #18 had clear speech and was understood/understands. Her cognition was intact. The Resident Council Meeting minutes were reviewed from December 2016-April 2017. The Resident Council minutes dated 12/27/16 revealed there was not enough nursing staff on the halls and not enough nursing staff in the dining rooms. The Resident Council minutes dated 2/7/17 revealed the nursing staff was not in the dining rooms on time and the residents were by themselves. The Resident Council minutes dated 3/21/17	F 244	F244 □ 483.10 Listen/Act on Group Grievance/Recommendation 1. Activities Director was immediately re-educated on ensuring concerns voiced during Resident Council Meeting are listed on Resident Council Concern Follow-Up Form to ensure follow up on all concerns. Director of Nursing spoke with Resident #18 about staffing concerns on 05/16/17. She stated she had seen an improvement in staffing over the last couple of months. Talked with her about staffing agencies and the people who would be coming in to work for 6 weeks at a time to help cover schedules. Also discussed with her that we have submitted a compensation review to corporate for review. 2. All concerns voiced during Resident Council Meeting will be listed on the Resident Council Concern Follow-Up Form and presented to the Resident Council President for review. Upon resolution of grievances, Activities Director will review with Resident Council President to ensure satisfaction with results. 3. Director of Nursing or Assistant Director of Nursing will audit and review Resident Council Concern Follow-Up Form monthly x 3 months to ensure all concerns are being addressed, followed up on with the Resident Council President, as well as reviewed at next Resident Council	

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F 244	Continued From page 6 revealed there was "not enough help" and no nursing staff in the dining room. The Resident Council minutes dated 4/11/17 revealed the nursing staff was not in the dining room. An interview was completed with Resident #18 on 4/29/17 at 9:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council brought up in the meetings. An interview was completed with the Activities Director on 4/29/17 at 10:21 AM. She reported that a nursing representative often came to the Resident Council meetings and would discuss concerns with the Council. She stated, "I just wrote down their complaints. I don't know if the department itself wrote down what they discussed, they may, they may not, I'm not sure." An interview was completed with the Director of Nursing (DON) on 4/29/17 at 10:39 AM. She stated she had been to the last two Resident Council meetings on 3/21/17 and 4/11/17. "We went in and talked to them and addressed their concerns." The DON reported she did not have any documentation to show how the Council's concerns were addressed. She stated if she can't cover the nursing schedule with her staff, she used office staff who were certified as nursing assistants. During a second interview with the DON on 4/29/17 at 3:51 PM she stated she thought the	F 244	Meeting. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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F 244	Continued From page 7 Activities Director had recorded on the minutes how concerns were being addressed and the DON had not documented any kind of follow up from the Resident Council. An interview was completed with the Administrator on 4/29/17 at 4:10 PM. He stated his expectation was that any concerns brought up in the Resident Council meeting would be addressed on a concern form.	F 244		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		5/29/17

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shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined

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F 280	Continued From page 9 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to invite the Responsible Party (RP) to participate in Care Plan meetings for 2 of 3 residents (resident #4 and resident #5) reviewed for notification of participation in Care Plan meetings. Findings included: 1. Resident #4 was admitted to the facility on 01/18/2010 with cumulative diagnoses which included Diabetes and Chronic pain. The Quarterly Minimum Data Set (MDS) dated 1/17/17 indicated that Resident #4 required 1 person assistance with Activities of Daily Living and was severely cognitively impaired. Medical Record review from April, 2016 until March 29, 2017 revealed no documentation of RP being invited to the care plan meeting nor any documentation of RP participating in the meeting. Medical Record review also confirmed that this family member was Resident #4's RP. Interview with Resident #4 was attempted on 4/28/2017 at 4:30 PM. She did not was not	F 280	F280 □ 483.10 Right to Participate Planning Care-Revise CP 1. (a) Resident #4 □ RP invited via mail to attend care plan meeting on 05/15/2017. Family attended care plan meeting and resident's plan of care was reviewed. (b) Resident #5 □ RP invited to care plan meeting on 05/15/2017. Family did not attend, however, MDS nurse met with Resident #5's daughter and reviewed care plan, medications, care cards, and overall status on 05/02/2017. 2. Schedule created to ensure all residents having the potential to be affected will have a care plan meeting by 05/26/2017. Letters mailed to families on 05/10/2017. Care plans will be scheduled quarterly thereafter with the quarterly MDS. Care plan meetings completed upon admission for new residents, and are scheduled quarterly thereafter. 3. Care plan team re-educated to components required to be in compliance with F280. Random audits will be completed on 5 residents (20 residents	

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F 280	Continued From page 10 respond to question asked: however, she talked about her significant other. Interview was conducted with Resident # 4's Responsible Party on 4/29/2017 at 9:30 AM. The RP stated she never received any notification of Care plan meetings. The RP indicated that she has been actively involved in the care of Resident #4 since her placement, but the staff would not involve her in the care and treatment of Resident #4. During an interview with the Social Worker on 4/29/2017 at 11 AM he revealed that he was aware that family member were not invited to the Care Plan meeting during the months of September 2016 through January 2017. He stated he was the assistant to the former Social Worker who left about two weeks ago. During a telephone interview with the former Social Worker on 4/29/17 at 1 PM she revealed that she did not have any written documentation of sending the resident's RP a letter to come to the Care Plan meeting. The former SW indicated she "would leave a notes in the resident rooms," and that there was no documentation kept during the care plan meeting, and there was no track of letters sent. During an interview with the Administrator on 4/29/2017 at 4:30 PM, he revealed that the facility Social Worker had a letter to send to each family inviting them to the resident's care plan meeting, but he was not aware the Social Worker did not issue the letters to families. The Administrator stated that his expectation was that the facility would invite family (RP) and residents to all Care Plan meetings and that the notification be issued	F 280	total) per hall by Director of Nursing, Assistant Director of Nursing, or designee to ensure care plan meetings are scheduled, family invited, and meetings occurred weekly x 4 weeks, then monthly x 3, or until no further issues noted. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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in a timely manner.

2. Resident #5 was admitted to the facility on 02/23/2016 with cumulative which included Anemia and Hypertension. The Quarterly Minimum Data Set (MDS) dated March 2, 2017 indicated that Resident #5 required 2 persons for assistance with Activities of Daily Living and was cognitively intact.

Medical Record review from March 2016 until March 29, 2017 revealed no documentation of RP being invited to the care plan meeting nor any documentation of RP participating in the meeting. Medical Record review also confirmed that this family member was Resident #5's RP.

Interview was conducted with Resident # 5's Responsible Party on 4/29/2017 at 10:30 AM. The RP stated she never received any notification of Care plan meetings. The RP indicated that she had been in the care and treatment of Resident #5.

Interview with Resident #5 was attempted on 4/29/2017 at 10:45 AM. She did not respond to question asked: however, the RP indicated that she had not been feeling well this week.

During an interview with the Social Worker on 4/29/2017 at 11 AM he revealed that he was aware that family member were not invited to the Care Plan meeting during the months of September 2016 through January 2017. He stated he was the assistant to the former Social Worker who left about two weeks ago.

During a telephone interview with the former Social Worker on 4/29/17 at 1 PM she revealed

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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 280	Continued From page 12 that she did not have any written documentation of sending the resident's RP a letter to come to the Care Plan meeting. The former SW indicated she "would leave a notes in the resident rooms," and that there was no documentation kept during the care plan meeting and there was no track of letters sent. During an interview with the Administrator on 4/29/2017 at 4:30 PM. The Administrator revealed that the facility Social Worker had a letter to send to each family inviting them to the resident's care plan meeting, but he was not aware the Social Worker did not issue the letters to families. The Administrator stated his expectation was that the facility would invite family (RP) and residents to all Care Plan meetings and that the notification be issued in a timely manner.	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment	F 323		5/29/17

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F 323	Continued From page 13 from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews, the facility failed to provide adequate supervision when providing ADL care (activities of daily living) to an agitated and combative resident which resulted in a fall with a contusion and laceration to the head for 1 of 3 residents reviewed for accidents. (Resident #2) Findings included: Resident #2 was admitted to the facility on 1/18/10 with diagnosis which included: dementia with Lewy bodies, chronic lymphedema, syncope and collapse, and a history of chronic hallucinations and psychosis. The Fall Risk Assessment dated 2/13/17 indicated Resident #2 was a high risk for falls. The Significant Change Minimum Data Set (MDS) dated 2/13/17 indicated Resident #2 had short and long term memory loss with moderately impaired decision-making skills; had behavior of rejecting care; was frequently incontinent of bladder and always incontinent of bowels. The MDS also indicated the resident required extensive assistance of two staff for bed mobility; and had no falls since the last assessment.	F 323	F323 □ 483.25 Free of Accident Hazards/Supervision/Devices 1. Resident #2 was immediately sent to emergency room for evaluation and treatment via Emergency Medical Services (EMS). NA#12 was immediately questioned as to the education she had received the previous week about providing Activities of Daily Living (ADL) care. She stated she did have the training, and she knew what she should have done, but she didn't call for extra help. NA#12 was immediately re-educated on providing care to a combative or agitated resident. NA#12 was then suspended, escorted out of facility by SN#8 and SN#9, who was also Manager on Duty. NA#12 did not work again in the facility and employment was terminated. 2. NA#12's employment was terminated. Direct care staff were re-educated on 04/06/2017 regarding combativeness, de-escalation and prevention. Staff will be given additional re-education on providing ADL care for combative residents to be completed by 05/29/2017. 3. Random audits will be completed by	

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F 323	Continued From page 14 Review of the Physician's Order dated 2/21/17 revealed fall mats were to be placed on each side of Resident #2's bed due to her history of falls. The order also revealed the resident received hospice care. The updated Care Plan dated 4/26/17 (after the resident's fall on 3/19/17) revealed the resident had a high risk for falls related to being unaware of safety needs, history of falls and diagnosis of lymphedema. Interventions included: (8/25/16)-staff would not attempt to transport resident when she was combative; (12/8/16)-floormat at bedside; and, (4/26/17)-one on one education with staff. The review of the "Side Rail In-service" conducted by the facility on 3/10/17-3/13/17 included: "Rolling the patient in bed: Always roll the patient towards you. Before rolling the patient, check: What is the patient's condition? Consider extra measures if they are confused, agitated or uncooperative". The signature of Nursing Assistant (NA)#12, was included on this in-service's attendance record. Review of the clinical records revealed on 3/19/17 Resident #2 became combative towards NA#12 during ADL care and slid out of the bed onto the floor mat hitting the back of her head on the base of an empty IV (intravenous) pole. The resident remained alert and oriented on the floor during an assessment by Staff Nurse (SN) #8. The resident complained of her head hurting. The resident was noted with a bleeding, 2 ½ inch laceration at the back of her head. The resident did not want to be touched and continued attempting to hit staff. The resident's neurological checks were within normal	F 323	Director of Nursing, Assistant Director of Nursing, or designee on 12 residents per week to ensure compliance with providing ADL care for combative or agitated residents weekly x 4 weeks, then monthly x 3, or until no further issues noted. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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limits. The resident was sent to the hospital for evaluation via emergency medical transport (EMT). The resident's family was notified. One-on-one education was provided to NA#12 which stated "During resident care, if a resident becomes agitated or displays behaviors, the aide providing care should step out of the room to get assistance in order to protect resident safety."

The review of the hospital emergency room summary dated 3/19/17 diagnosed Resident #2 with a contusion of her head, no loss of consciousness with minimal bleeding. The physical exam of the resident's head revealed a hemostatic (healing) abrasion of the posterior scalp, normocephalic. CT (computerized tomography) scan revealed the resident had no acute intracranial abnormality; no evidence of acute cervical fracture.

During an interview on 4/26/17 at 5:14 pm, the Director of Nursing (DON) stated that on 3/10/17 NA#12 attended the Side Rail In-service which included how to handle residents who were combative. The DON revealed that on 3/19/17, NA#12 was involved in an incident in which Resident #2 was combative with the NA during ADL care causing the resident to hit her head when she fell from the bed to the floor. As a result, the NA was suspended, then her employment with the facility was terminated the next day.

During an interview on 4/27/17 at 3:35 pm, the facility's District Director of Clinical Services revealed the incident on 3/19/17 was a result of a fall with a bump to the resident's head. She stated that when sent to the hospital for evaluation the resident had minimal bleeding, did not require any

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steri-strips or stitches, the CT scan and x-rays were negative, and the resident returned to the facility the same day. The District Director also revealed: upon investigation, NA#12 was found to not have followed protocol when providing ADL care for Resident #2 on 03/10/17. The District Director of Clinical Services stated that on 03/19/17 there should have been two staff members providing ADL care for Resident #2 who was combative. When NA#12 was reminded of the most recent in-service on providing ADL care to combative residents, NA#12's reply was "yes, I know what I should have done, I just didn't". As a result of the NA's response, NA#12's employment with the facility was terminated. Re-education on combativeness, de-escalation and prevention was provided on 4/6/17 to all direct care staff.

The interview on 4/27/17 at 4:48 pm revealed SN#9 was the Manager on Duty on 3/19/17 when the accident occurred. SN#9 stated that she was informed by one of the staff nurses that Resident #2 had fallen in her room during incontinent care provided by NA#12. EMT had been called by SN#8. Upon arrival to the resident's room, SN#9 indicated she observed the resident lying on the floor on her back, alert, not drowsy or lethargic, but had a moderate amount of bleeding from the back of the resident's head. The hall nurse assessed the resident and the two hall NAs obtained the resident's vital signs. EMT arrived, the resident became agitated, but the paramedics were able to get the resident on the stretcher and transported her to the hospital. SN#9 revealed she was given a full report of the incident from SN#8. The DON telephoned the facility and instructed SN#8 and SN#9 to provide one-on-one re-education on when a resident becomes agitated during care, the nursing assistant was to

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ensure the resident's safety, leave the room and request assistance from a nurse or another nursing assistant. Both NAs assigned on the hall at the time of the accident, including NA #12, received the re-education and signed the acknowledgement. SN#9 indicated the DON telephoned the facility again and informed NA#12 she was suspended at that time. SN#9 and SN#8 escorted NA#12 out of the facility.

On 4/28/17 at 10:48 am, unsuccessful attempts to contact NA#12 resulted in a service provider's message indicating the phone number was no longer in service. The DON revealed the attempted phone number was the only one provided to the facility by NA#12.

During an observation on 4/28/17 at 12:53 pm, Resident #2 was asleep in the bed in a fetal position. The head of the bed was up at approximately 80 degrees and both quarter side rails were up (located towards middle of bed). Floor mats were on each side of the bed which was in the standard position. The privacy curtain was drawn due to two hospice nursing assistants were providing care to the resident in bed B.

During an interview on 4/28/17 at 1:16 pm, Hospice NA#13 revealed she and one other hospice NA provided ADL care to Resident #2, five days each week at approximately 2:00 pm. She also revealed two hospice staff were required when turning and repositioning the resident. Hospice NA#13 stated that the resident was non-ambulatory. She indicated the resident was never combative during care but would become agitated whenever her legs were touched, repositioned or moved.

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During an interview on 4/28/17 at 1:36 pm, NA#1 indicated Resident #2 was mostly bedbound, required two staff for all of her ADL care and was totally incontinent of bowel and bladder. NA#1 stated that the resident was turned and repositioned every hour. She revealed the resident would complain of leg pain and cry out whenever her legs were moved or touched. NA#1 would inform the nurse and the resident would be given pain medication. NA#1 stated that the resident had areas on both of her lower legs due to lymphedema.

During a telephone interview on 4/28/17 at 2:21 pm, SN#8 revealed she was on duty at the time of Resident #2's accident on 03/19/17. SN#8 stated that NA#12 notified her that Resident#2 had fallen from her bed to the floor. Upon entering the resident's room, SN#8 observed the resident lying on her back on the floor between bed A and B. The resident was conscious. SN#8 indicated that without moving the resident from the floor, she conducted an assessment of the resident. SN#8 observed bleeding at the back of the resident's head (right above her neck), pressure was applied with a washcloth. Neurological checks were started during the assessment and continued for three days. Vital signs were taken and within normal limits. She noted the IV pole between the closets of bed A and B with one of the legs at the base protruding outward (approximately four inches) where the resident was lifting her head. She recalled the resident had completed IV fluids the prior week. SN#8 indicated the IV pole should have been removed from the resident's room. SN#8 revealed that when EMT arrived the bleeding to the resident's head had decreased but not stopped. The resident complained that her legs

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F 323	Continued From page 19 and head hurt. The resident was sent to the hospital emergency room. SN#8 stated that following Resident #2's fall on 03/19/17, NA #12 reported to her that she went into the resident's room to provide incontinent care. NA#12 informed SN#8 that she turned Resident#2 onto her left side (towards the window) away from NA#12; the resident was holding the side rail with her left hand while swinging her right arm backwards attempting to hit NA#12 when the resident's legs slid to the floor around the side rail and hit her head on the base of the IV pole.	F 323		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		5/29/17

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F 353	Continued From page 20 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide sufficient staffing to provide supervision when assisting with activities of daily living (ADL) care for 1 of 3 residents and failed to follow their infection control policy on 2 of 4 halls. This tag is cross referenced to tags F323 and F441. Findings included: 1. F323 Based on observation, record reviews, and staff interviews, the facility failed to provide adequate supervision when providing ADL care (activities of daily living) to an agitated and combative resident which resulted in a fall with a contusion and laceration to the head for 1 of 3	F 353	F353 □ 483.35 Sufficient 24-HR Nursing Staff per Care Plans 1. (a) Resident #2 was immediately sent to emergency room for evaluation and treatment via Emergency Medical Services (EMS). NA#12 was immediately questioned as to the education she had received the previous week about providing Activities of Daily Living (ADL) care. She stated she did have the training, and she knew what she should have done, but she didn't call for extra help. NA#12 was immediately re-educated on providing care to a	

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F 353	Continued From page 21 residents reviewed for accidents (Resident #2). 2. F441 Based on observations, record reviews and staff interviews the facility failed to follow their Infection Control policy entitled "Contact Isolation" for residents on 2 of 4 halls (200 and 300 halls). An interview was completed with Nurse Aide #2 (NA) on 4/27/17 at 1:30 PM. She stated because there are only 2 nurses' aides on each hall that sometimes residents had to wait a little longer to receive care. An interview was completed with the Director of Nursing (DON) on 4/27/17 at 3:09 PM. She reported there had been issues with staffing and that she had pulled administrative nursing staff to work when staffing is short. She stated the facility social worker had left recently and "took a lot of staff with her." An interview was completed with Resident #18 on 4/29/17 at 9:37 AM. She stated the issues with staffing were discussed in Resident Council meetings, including that there was not enough nursing staff on the halls. Resident #18 reported that the facility had not specifically addressed ways they were resolving the issues the Resident Council brought up in the meetings. An interview was completed with the Activities Director on 4/29/17 at 10:21 AM. She stated she has worked the hall at times (she is also a certified nursing assistant), most recently 4/28/17 from 3 PM-6 PM. She reported the DON had asked, "can you just go down 'A' hall for a little bit?" She stated nursing administration had asked her sometimes if she wanted to work the weekend. The Activities Director said that on a	F 353	combative or agitated resident. NA#12 was then suspended, escorted out of facility by SN#8 and SN#9, who was also Manager on Duty. NA#12 did not work again in the facility and employment was terminated. Currently have contract with two staffing agencies, in the process of obtaining contracts with another staffing agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. (b) Staff were immediately re-educated on Contact Isolation and Personal Protective Equipment (PPE). Currently have contract with two staffing agencies, in the process of obtaining contract with another staffing agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. 2. (a) NA#12's employment was terminated. Direct care staff were re-educated on 04/06/2017 regarding combativeness, de-escalation and prevention. Staff will be given additional re-education on providing ADL care for combative residents to be completed by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining contract with another staffing agency to ensure sufficient staffing. Facility administrator created a wage compensation package for review. (b) Nursing, housekeeping, therapy and office staff will be retrained on Hand Hygiene, Hand washing, Contact Isolation and PPE by 05/29/2017. Currently have contract with two staffing agencies, in the process of obtaining a contract with another staffing agency to ensure	

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F 353	Continued From page 22 rare occasion, she had to rearrange the activities schedule to accommodate other duties she was asked to help with. An interview was completed with the DON on 4/29/17 at 10:39 AM. She confirmed she had used the Activities Director to fill in as a NA on 4/28/17 because "there was an open spot" on the schedule. She stated "if we can't cover with the normal pool of people we go to the office staff" (ward clerk/medical records, central supply, activities director), who were all certified nursing assistants. A second interview was completed with the DON on 4/29/17 at 3:51 PM. She stated the facility had recently lost some staff and that office staff had worked the floor within the last two weeks. "This is because we don't have a pool of people to ask from." Both the DON and Assistant Director of Nursing (ADON) worked a hall from 3-7 AM on 4/29/17 because one nurse called in sick and there was no one available to cover the other hall. The DON said that her expectation was that there would be enough staff in the building to provide nursing services to the residents.	F 353	sufficient staffing. Facility administrator created a wage compensation package for review. 3. (a) Random audits will be completed by Director of Nursing, Assistant Director of Nursing, or designee on 12 residents per week to ensure compliance with providing ADL care for combative or agitated residents weekly x 4 weeks, then monthly x 3, or until no further issues noted. Schedule will be reviewed by Director of Nursing or Assistant Director of Nursing Monday through Friday to ensure sufficient staffing in place daily x 4 weeks, then weekly x 4 weeks, then monthly x 3, or until no further issues noted. (b) Director of Nursing, Assistant Director of Nursing or designee will complete audits on all halls to ensure compliance weekly x 4 weeks, then monthly x 3. Schedule will be reviewed by Director of Nursing or Assistant Director of Nursing Monday through Friday to ensure sufficient staffing in place daily x 4 weeks, then weekly x 4 weeks, then monthly x 3, or until no further issues noted. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		5/29/17

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F 431	Continued From page 23 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 24 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to remove 1 Humalog insulin pen, 1 Lantus pen, 1 Novolog Mix 70/30 pen, 3 Novolog Flex pens and 1 Levemir insulin pen that were not labeled or dated when opened for use in 3 of 4 medications carts on 100, 200 and 300 halls. Staff also failed to remove 4 multidose vials of Lidocaine that were opened and not labeled available for use in 2 of 4 medication carts on 100 and 300 hall medication carts and also failed to remove 1 vial of sterile water for injection from 1 of 4 carts on 300hall. Findings included: A review of the facility policy entitled Medication Storage in the Facility, Storage of Medications Section 4.1 dated May 2012 indicated that certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solutions and strips, once opened, require an expiration date shorter than the manufactures expiration date to insure medication purity and potency. It further states that when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. A further review of the facility policy also indicates that the nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a "date opened" and	F 431	F431 □ 483.45 Drug Records, Label/Store Drugs & Biologicals 1. (a) Insulin pen for Resident #1 was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (b)Insulin pen for Resident #14 was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (c)Insulin pen for Resident #15 was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. The seven insulin pens in question were removed immediately from the medication	

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F 431	Continued From page 25 "expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines requires different dating. The policy indicates that the nurse will check the expiration date or each medication before administering it, that no expired medication will be administered to a resident, that all expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining and the medication will be destroyed in the usual manner. The policy also indicates that the nursing staff should consult with the dispensing pharmacist for any questions related to medication expiration dates. A review of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 indicates that opened Humalog, Lantus and Novolog pens at room temperature are to be discarded after 28 days, Novolog Mix 70/30 pens are to be discarded after 14 days and Levemir pens are to be discarded after 42 days. A review of the facility policy entitled Expiration Dates indicates that Lidocaine (multidose) vials stored at room temperature are to be discarded 30 days after opened. A review of the facility policy entitled Recommend Minimum Medication Storage Parameters (based on manufacturer guidance) Injectable Medications indicates that Bacteriostatic (sterile) Water for injection should be dated when opened and discarded 28 days after first use. 1. Resident #1 was admitted to the facility on 06/13/2016 and diagnoses included diabetes mellitus (DM). A physician's order dated 12/08/2016 indicated that Resident #1 receive Novolog Solution 100u/ml via Pen, inject 20 units subcutaneously (SQ) before meals related to DM	F 431	cart and discarded. The four multidose vials of Lidocaine in question were removed immediately from the medication carts and discarded. The one vial of sterile water for injection was removed immediately from the medication cart and discarded. Nurses that were present were immediately re-educated on med storage and labeling meds with date when opened. (d) Insulin pen for Resident #16 was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (e) Insulin pen for Resident #17 was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (f) (1) Multidose vials of Lidocaine were immediately removed from medication cart and discarded. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (f) (2) Multidose vial of Sterile Water for Injection was immediately removed from medication cart and discarded. Re-education on expiration date of medications completed for all nurses on	

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F 431	Continued From page 26 and use Novolog Flex Pen Solution to cover the sliding scale dose ordered. On 04/26/2017 at 4:45PM Resident #1's Novolog pen was observed on the 200hall medication cart ready for use and was opened, had no sticker in place and undated. On 04/26/2017 at 4:45PM an interview was conducted with Nurse #1. She stated that she had used the Novolog pen located on 200 hall med cart for Resident #1 for the morning dose. When asked what the expiration date for Novolog Flex Pen was she stated the manufacturer expiration date on the pen and confirmed that she did not know when Novolog expired once out of the refrigerator and opened. She stated that a dated label should be on the pen and would have indicated the date opened. She confirmed that she did not know when Resident #1's Novolog pen was opened and without an opened date she was unable to determine if Resident #1's Novolog pen had expired prior to her administering the insulin on 04/26/2017. She confirmed that she did not look for the label or opened date and that injectable medication should be removed from the cart and discarded when it is expired. She immediately removed the undated Novolog pen from the 200hall medication cart and discarded it. On 04/26/2017 at 5:00PM a review of the Medication Administration Record (MAR) revealed that Resident #1 received Novolog 2 units on 04/27/2017 at 12Noon per physician's orders as indicated by Nurse #1's documentation on the MAR. On 04/26/2017 at 5:20PM an interview was conducted with the Assistant Director of Nursing (ADON) who stated that her expectation was the nursing staff would have dated the Novolog pen for Resident #1 when it was opened as per facility policy. She stated that her expectation was that	F 431	04/27/2017 during first and second shift. (g) (1) Multidose vials of Lidocaine were immediately removed from medication cart and discarded. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. (g) (2) Insulin pen for unknown resident that was undated was immediately removed from medication cart and discarded. Facility policy entitled Insulin Storage Recommendation was placed in a notebook on the medication cart as a reference. Re-education on expiration date of medications completed for all nurses on 04/27/2017 during first and second shift. 2. 100% audit of all medication carts were checked to ensure all opened medications that require a date were dated. All nurses will be re-educated on labeling meds when opened. 3. Director of Nursing, Assistant Director of Nursing, Staff Development Manager, MDS nurses will perform daily cart audits daily, 5x/week x 4 weeks, then weekly x 3 months. Director of Nursing, Assistant Director of Nursing, or Staff Development Manager to do random weekly checks thereafter to ensure compliance. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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the nursing staff, per facility protocol, would have checked that Resident #1's Novolog pen was dated when opened prior to administering the Novolog pen to Resident #1 the morning of 04/26/2017 and that nursing staff would have identified that Resident #1's Novolog pen was not dated when opened and would have to be discarded prior to administration because without an opened date there was no way to determine when the Novolog pen had expired. Her prompt action plan identified placing a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.

On 04/27/2017 at 2:00PM an interview was conducted with the Director of Nursing (DON) who stated that her expectation was that the nursing staff would have labeled the insulin pen per facility policy and would have not administered medication to a resident without a known expiration date. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced medication cart checks will be done daily by DON, ADON, Staff Development Manager (SDM) and Minimum Data Set (MDS) nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multidose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in the building per physician order.

On 04/27/2017 at 2:46PM an interview with the Clinical Pharmacist along with DON stated that his expectation is that all insulin should be labeled and dated immediately when removed from refrigeration and knowing the difference in how

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long until they should be discarded and this information can be found in the facility policy.
On 04/29/2017 at 11:30am an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the mediation carts within the facility and that this education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He stated that his expectation is that prior to administering insulin to Resident #1, staff should have check that the insulin had been labeled appropriately with an opened date as per facility protocol.
2. Resident #14 was admitted to the facility on 04/21/2017 and diagnoses included DM. A physician's order dated 04/21/2017 indicated that Resident #14 receive Novolog Solution 100u/ml via Pen before meals SQ to cover the sliding scale dose ordered. Another physician's order dated 04/21/2017 indicated that Resident #14 receive Lantus SoloStar Solution Pen 100units/ml, inject 5 units SQ one time a day.
On 04/26/2017 at 4:45PM Resident #14's Novolog and Lantus pens were observed on the 200hall medication cart ready for use and was opened and undated.
On 04/26/2017 at 4:45PM an interview was conducted with Nurse #1. She stated that she had used the Lantus pen located on 200 hall med cart for Resident #14 for the morning dose. She stated that she had not needed to use the Novolog pen on 04/26/2017 for Resident #14 per physician orders. When asked what the expiration date for Lantus and Novolog Pens

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were, she stated she did not know the date and confirmed that she did not know when Lantus nor Novolog expired once opened and were out of the refrigerator. She confirmed that a dated label would have indicated the date opened. She confirmed that she did not know when Resident #14's Lantus and Novolog pens were opened and without an opened date she was unable to determine if Resident #14's Lantus and Novolog pens had expired prior to her administering the Lantus on 04/26/2017. She confirmed that she did not look for the label or the opened date and that injectable medication should be removed from the cart and discarded when it is expired. She immediately removed the undated Lantus and Novolog pens from the 200hall medication cart and discarded them.

On 04/26/2017 at 5:00PM a review of the MAR revealed that Resident #14 received Lantus 5 units on 04/27/2017 at 9:00AM per physician's orders as indicated by Nurse #1's documentation on the MAR.

On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her expectation was the nursing staff would have dated the Lantus and Novolog pens for Resident #14 when it was opened as per facility policy. She stated that her expectation was that the nursing staff, per facility protocol, would have checked that Resident #14's Lantus pen was dated when opened prior to administering the Lantus to Resident #14 the morning of 04/26/2017 and that nursing staff would have identified that Resident #14's Lantus and Novolog pens were not dated when opened and would have to be discarded prior to administration because without a correctly labeled opened date there was no way to determine when the Lantus and Novolog pens had expired. He prompt action plan was to place

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a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.
On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the insulin pens per facility policy and would have not administered medication to a resident without a known expiration date. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multidose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in the building per physician order.
On 04/27/2017 at 2:46PM an interview with the Clinical Pharmacist along with DON stated that his expectation is that all insulin should be labeled and dated immediately when removed from refrigeration and knowing the difference in how long until they should be discarded and this information can be found in the facility policy.
On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the mediation carts within the facility and that the education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been

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reeducated. He specified that his expectation is that prior to administering insulin to Resident #14, staff should have checked that the insulin had been labeled appropriately with an opened date as per facility protocol.
3. Resident #15 was admitted to the facility on 08/17/2015 and diagnoses included DM. A physician's order dated 10/13/2016 indicated that Resident #15 receive Humalog Solution 5 units via pen SQ before meals.
On 04/26/2017 at 4:45PM Resident #15's Humalog pen was observed on the 200hall medication cart ready for use and was opened and undated.
On 04/26/2017 at 4:45PM an interview was conducted with Nurse #1. She stated that she had used the Humalog pen located on 200 hall med cart for Resident #15 for the morning, lunch and evening doses. When asked what the expiration date for Humalog Pens was, she stated she did not know it and that confirmed that she did not know when Humalog expired once opened and out of the refrigerator. She stated that a completed label would have indicated the date opened and that she did not know when Resident #15's Humalog pen was opened. She stated that without an opened date she was unable to determine if Resident #15's Humalog pen had expired prior to her administering the Humalog on 04/26/2017. She confirmed that she did not look for the label with the opened date and that injectable medication should be removed from the cart and discarded when it is expired. She immediately removed the undated Humalog pen from the 200hall medication cart and discarded it.
On 04/26/2017 at 5:00PM a review of the MAR revealed that Resident #15 received Humalog 5 units on 04/27/2017 at 7:30AM, 11:30AM and

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4:30PM per physician's orders as indicated by Nurse #1's documentation on the MAR.
On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her expectation was the nursing staff would have dated the Humalog pen for Resident #15 when it was opened as per facility policy. She stated that her expectation was that the nursing staff, per facility protocol, would have checked that Resident #15's Humalog pen was dated when opened prior to administering the Humalog to Resident #15 three times the day of 04/26/2017 and that nursing staff would have identified that Resident #15's Humalog log pen was not dated when opened and would have to be discarded prior to administration because without an opened date there was no way to determine when the Humalog log pen had expired. Her prompt action plan was to place a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.
On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the insulin pens per facility policy and would have not administered medication to a resident without a known expiration date. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multidose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in the

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building per physician order.
On 04/27/2017 at 2:46PM an interview with the Clinical Pharmacist along with DON stated that his expectation is that all insulin should be labeled and dated immediately when removed from refrigeration and knowing the difference in how long until they should be discarded and this information can be found in the facility policy.
On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the mediation carts within the facility and that the reeducation had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He specified that his expectation is that prior to administering insulin to Resident #15, staff should have check that the insulin had been labeled appropriately with an opened date as per facility protocol.
4. Resident #16 was admitted to the facility on 03/25/2017 and diagnoses included DM. A physician's order dated 04/26/2017 indicated that Resident #16 receive Levemir Solution100u/ml, 38 units in the evening SQ before meals.
On 04/26/2017 at 4:45PM Resident #16's Levemir pen was observed on the 200hall medication cart ready for use and was opened and undated.
On 04/26/2017 at 4:45PM an interview was conducted with Nurse #1. She stated that the Levemir pen located on 200 hall med cart for Resident #16 was used at 8:00PM on 04/25/2017 by another nurse per the MAR documentation. When asked what the expiration date for Levemir

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Pens was, she stated she did not know. She confirmed that she did not know when Levemir expired once out of the refrigerator and opened and that a dated label would have indicated the date opened and that she did not know when Resident #16's Levemir pen was opened. She stated that without an opened date she was unable to determine if Resident #16's Levemir pen had expired prior to the last administration of Levemir on 04/25/2017 and that injectable medication should be removed from the cart and discarded when it is expired. She immediately removed the undated Levemir pen from the 200hall medication cart and discarded it.

On 04/26/2017 at 5:00PM a review of the MAR revealed that Resident #16 received Levemir 38 units on 04/25/2017 at 8:00PM per physician's orders as indicated by documentation on the MAR.

On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her expectation was the nursing staff would have dated the Levemir pen for Resident #16 when it was opened as per facility policy. She stated that her expectation was that the nursing staff, per facility protocol, would have checked that Resident #16's Levemir pen was dated when opened and that nursing staff would have identified that Resident #16's Levemir pen was not dated when opened and would have to be discarded prior to administration because without an opened date there was no way to determine when the Levemir pen had expired. Her prompt action plan was to place a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.

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F 431	Continued From page 35 On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the insulin pens per facility policy and would have not administered medication to a resident without a known expiration date. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multidose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in the building per physician order. On 04/27/2017 at 2:46PM an interview with the Clinical Pharmacist along with DON stated that his expectation is that all insulin should be labeled and dated immediately when removed from refrigeration and knowing the difference in how long until they should be discarded and this information can be found in the facility policy. On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the mediation carts within the facility and that the education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He specified that his expectation is that prior to administering insulin to Resident #16, staff should have check that the insulin had been labeled appropriately with an opened date as per facility protocol.	F 431		

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5. Resident #17 was admitted to the facility on 04/06/2017 and diagnoses included DM. A physician's order dated 04/06/2017 indicated that Resident #17 receive Novolog Mix 70/30 Flex Pen Suspension pen injector 100u/ml, inject 12units SQ in the evening.
On 04/26/2017 at 4:45PM Resident #17's Novolog 70/30 Mix pen was observed on the 200hall medication cart ready for use and was opened and undated.
On 04/26/2017 at 4:45PM an interview was conducted with Nurse #1. She stated that she had used the Novolog 70/30 Mix Pen located on 200 hall med cart for Resident #17 for the evening dose. When asked what the expiration date for Novolog 70/30 Mix Pen was, she stated she did not know and did not know when Novolog 70/30 Mix expired once opened and out of the refrigerator. She confirmed that a dated label would have indicated the date opened and that she did not know when Resident #18's Novolog 70/30 Mix Pen was opened and without an opened date she was unable to determine if Resident #17's Novolog 70/30 Mix Pen had expired prior to her administering the Novolog 70/30 Mix on 04/26/2017. She confirmed that she did not look for the dated label and that injectable medication should be removed from the cart and discarded when it is expired. She immediately removed the undated Novolog 70/30 Mix Pen from the 200hall medication cart and discarded it.
On 04/26/2017 at 5:00PM a review of the MAR revealed that Resident #17 received Novolog 70/30 Mix 10 units on 04/25/2017 at 9:41PM per physician's orders as indicated by documentation on the MAR.
On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her

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expectation was the nursing staff would have dated the Novolog 70/30 Mix Pen for Resident #17 when it was opened as per facility policy. She stated that her expectation was that the nursing staff, per facility protocol, would have checked that Resident #17's Novolog 70/30 Mix Pen was dated when opened and that nursing staff would have identified that Resident #17's Novolog 70/30 Mix Pen was not dated when opened and would have discarded prior to administration of the insulin because without an opened date there was no way to determine when the Novolog 70/30 Mix Pen had expired. Her prompt action plan was to place a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.

On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the insulin pens per facility policy and would have not administered medication to a resident without a known expiration date. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multidose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in the building per physician order.

On 04/27/2017 at 2:46PM an interview with the Clinical Pharmacist along with DON stated that his expectation is that all insulin should be labeled and dated immediately when removed from refrigeration and knowing the difference in how

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long until they should be discarded and this information can be found in the facility policy.
On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the medication carts within the facility and that the education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He specified that his expectation is that prior to administering insulin to Resident #17, staff should have check that the insulin had been labeled appropriately with an opened date as per facility protocol.
6. On 04/26/2017 at 5:10PM an observation revealed on 1 of 4 medication carts on 300hall, three Lidocaine multi dose vials and one Sterile Water for injection multi dose vial were opened and not labeled or dated with open date. These vials were on the cart at ready for use.
a. On 04/26/2017 at 5:10PM an interview with Nurse #3 revealed that she did not know when the multi dose vials of Lidocaine was opened and did not know the expiration date of an opened Lidocaine multi dose vial. She confirmed that the vials were available to use on 300hall medication cart and that any medication or vial that is opened and undated should not be given to any resident. She stated that the vials should be discarded and use a new one when needed. She discarded the 3 Lidocaine vials per facility policy.
b. On 04/26/2017 at 5:10PM an interview with Nurse #3 revealed that she did not know when the Sterile Water used for injection multi dose vial was opened and that she did not know the

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expiration date of an opened Sterile Water multi dose vial. She confirmed that the Sterile Water vial was available and ready for use on 300hall medication cart and that any medication or vial that is opened and undated should not be given to any resident. She stated that the Sterile Water vial should be discarded. She discarded the Sterile Water vial per facility policy.

On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her expectation was the nursing staff would have dated the Lidocaine and Sterile Water multi dose vials when they were opened per facility policy and that the all nursing staff check that any medication on their cart that is opened and ready for use had been labeled with an opened date. She stated her expectation was that nursing staff would remove all opened and undated vials from their medication cart. He prompt plan of action was to place a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.

On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the multi dose vials per facility policy and would have removed the vials from the medication carts to prevent use of any opened and unlabeled medication. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced that medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multi dose vials and dating when opened and match

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back procedure Sunday nights on third shift to ensure we have all medications in the building per physician order.
On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the medication carts within the facility and that the education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He specified that all opened and unlabeled medication should be immediately removed and discarded from all medication carts per facility policy.
Again same comments.
7. On 04/26/2017 at 5:15PM an observation revealed on 1 of 4 medication carts on 100hall, one Lidocaine multi dose vial and one unlabeled Novolog Pen were opened and available for use.
a. On 04/26/2017 at 5:15PM an interview with Nurse #4 revealed that she did not know when the multi dose vial of Lidocaine was opened and did not know the expiration date of an opened Lidocaine multi dose vial. She confirmed that the vial was available to use on 100hall medication cart and that any medication or vial that is opened and undated should not be given to any resident. She stated that the vial should be discarded and use a new one when needed. She discarded the Lidocaine vial per facility policy.
b. On 04/26/2017 at 5:15PM an interview with Nurse #4 revealed that she did not know when the Novolog Pen was opened and to whom it belonged and did not know the expiration date of an opened Novolog Pen. She stated that the

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Novolog Pen was available and ready for use on 100hall medication cart and that any medication or vial that is opened and undated should not be given to any resident. She stated that the Novolog Pen should be discarded. She discarded the Sterile Water vial per facility policy.

On 04/26/2017 at 5:20PM an interview was conducted with the ADON who stated that her expectation was the nursing staff would have dated the Lidocaine and labeled and dated the Novolog Pen when they were opened as per facility policy and that her expectation was that the all nursing staff check that any medication on their cart that is opened and ready for use had been labeled with an opened date. She stated her expectation was that nursing staff would remove all opened and undated vials from their medication cart. Her prompt plan of action was to place a copy of the facility policy entitled Insulin Storage Recommendation with a revision date of September 29, 2014 on top of all 4 medication carts and in their information notebook located inside of their cart as a reference.

On 04/27/2017 at 2:00PM an interview was conducted with the DON who stated that her expectation was that the nursing staff would have labeled the multi dose vial and Novolog Pen per facility policy and would have removed the vial and pen from the medication carts to prevent use of any opened and unlabeled medication. She stated that they initiated reeducation of all staff on 04/27/2017 during first and second shift that announced that medication cart checks will be done daily by DON, ADON, Staff SDM and MDS nurse and every Monday night on third shift checking for expiration dates of medications, insulin and multi dose vials and dating when opened and match back procedure Sunday nights on third shift to ensure we have all medications in

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F 431	Continued From page 42 the building per physician order. On 04/29/2017 at 11:30AM an interview with the Administrator was conducted and stated that it is his expectation that nurses administer, label and date all necessary medication when opened per policy. He confirmed that the DON and ADON had initiated reeducation to the nursing staff in regards to expiration dates of open medication on the medication carts within the facility and that the education had taken place with the nursing staff working first and second shifts on 04/26/2017 and would continue until all nursing staff had been reeducated. He specified that all opened and unlabeled medication should be immediately removed and discarded from all medication carts per facility policy.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		5/29/17

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F 441	Continued From page 43 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the	F 441		

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F 441	Continued From page 44 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to follow their Infection Control policy entitled "Contact Isolation" for residents on 2 of 4 halls (200 and 300 halls). Findings include: The policy for Contact Precautions with a date of 2012 indicates that Direct Contact Transmission occurs when microorganisms are transmitted directly from person to person and Indirect Contact Transmission occurs when a transfer of the infectious agent through contacting a contaminated intermediate object or person. The same policy also states the following on pages 11 and 12: II. GLOVES AND HAND HYGIENE A. Hand hygiene should be completed prior to donning gloves. B. Gloves should be worn when entering the room while providing care to the resident. C. Gloves should be changed after having contact with infective material. D. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. E. After glove removal and hand hygiene, hands should not touch potentially contaminated surfaces or items. III. GOWNS	F 441	F441 □ 483.80 Infection Control, Prevent Spread, Linens 1. Staff were immediately re-educated on Hand washing, Contact Isolation and Personal Protective Equipment (PPE). 2. All nursing, housekeeping, therapy and office staff will be retrained on Hand washing, Contact Isolation and PPE by 05/26/2017. 3. Director of Nursing/Assistant Director of Nursing or designee will complete audits on all halls to ensure compliance weekly x 4 weeks, then monthly x 3. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	

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F 441	Continued From page 45 A. A gown should be donned prior to entering the room or resident's cubicle. B. The gown should be removed before leaving the resident's s room. C. After removal of the gown, clothing should not contact potentially contaminate environmental surfaces. VI. CONTACT PRECAUTIONS MAY BE CONSIDRED FOR (EXAMPLES): A. Multi drug resistant organism (e.g. MRSA, VRE, ESBL's, KPCs, resist (Acinetobacter baumannii) B. Scabies C. Clostridium difficile and other infections causes of diarrhea. D. Uncontained draining wounds. Diagrams on pages 12 and 13 demonstrated proper PPE placement and removal. 1a. On 04/26/2017 at 6:10PM an observation during supper meal tray pass on 300hall revealed CNA #8 had entered room 316 to assist with positioning resident and meal tray setup without washing hands or wearing personal protective equipment (PPE) even though there was a Contact Isolation sign on the door and did not perform hand hygiene after exiting the room. On 4/26/2017 at 6:13PM, an interview with CNA #8 revealed that she didn't understand when it was okay to go in a room without it on versus when they should wear it because it is changes all the time. She stated that the isolation sign on the door of room 316 clearly describes what pieces of PPE are to be worn by staff before entering the room. She stated that she did not wear gloves into the room but that she did move the tray table closer to the resident in first bed. She stated that she will speak with the director	F 441		

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about what is expected of staff when entering a room to deliver trays.
b. On 4/27/2017 at 6:15PM an observation performed during supper meal tray pass on 200hall revealed CNA #10 had entered room 205 with a meal tray, assist resident with positioning and setup tray table without washing hands or wearing PPE even though there was a Contact Isolation sign on the door and did not perform hand hygiene when exiting the room.
c. On 4/26/17 at 6:20PM an observation revealed CNA #10 had entered room 212 with a meal tray, assist resident with positioning and setup tray table without washing her hands or wearing PPE even though there was a Contact Isolation sign on the door and did not perform hand hygiene when exiting the room.
d. On 4/26/17 at 6:25PM an observation revealed the Assistant Director of Nursing (ADON) had entered room 212 with a meal tray, assist resident with positioning and setup bedside tray table without washing her hands or wearing PPE even though there was a Contact Isolation sign on the door and did not perform hand hygiene when exiting the room.
e. On 4/26/17 at 6:30PM an observation revealed the Admissions Manager had entered room 205 to setup bedside tray table without washing her hands or wearing PPE even though there was a Contact Isolation sign on the door and did not perform hand hygiene when exiting the same room.
f. On 4/26/17 at 6:35pm an observation revealed CNA #10 had entered room 206 to assist resident with bedside tray table and meal setup without washing her hands or wearing any PPE even though there was a Contact Isolation sign on the door and did not perform hand hygiene when exiting the same room.

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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 441	Continued From page 47 On 04/27/2017 at 4:00PM, a review of staff in-service log dated February 2017 revealed that staff received education regarding Infection Control with a focus on infection control policies, proper PPE use, cross contamination, glove use and disposal of isolation. On 04/27/2017 at 5:15PM, an interview with the Director of Nursing (DON) revealed that her expectation is that all staff follow the Contact Isolation guidelines set in place and posted on the resident room door regardless of the reason for entering the room. She also stated that they initiated reeducating staff about Infection Control and Contact Isolation starting on 2nd shift on 04/27/2017. On 04/29/2017 at 11:30AM an interview with the Administrator revealed that it is his expectation that all staff adhere to the facility Infection Control policy and follow the Contact Isolation guidelines as instructed at all times to prevent cross contamination.	F 441		
F 520 SS=D	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 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	F 520		5/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 04/29/2017

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F 520	Continued From page 48 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 observations and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on March, 2017. This was for recited deficiency, which was originally cited in accident (F323) on a complaint survey on 3/16/2017. The deficiency was in the area of F323.This deficiency was cited again on 4/29/2017 on a follow up and complaint survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality	F 520	F520 □ 483.75 QAA Committee □ Members/Meet Quarterly/Plans 1. A QAPI meeting will be held on 5/24/2017 to discuss F323 (483.25 Free of Accident Hazards/Supervision/Devices) and develop an immediate plan for improvement and to ensure practices are being maintained. 2. The District Director of Clinical Services will provide education to the QAPI members. Education will be completed by	

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F 520	Continued From page 49 Assurance (QA) Program. Finding Included: This tag is cross referenced to F 323- Based on observation, record review and staff interview the facility failed to provide adequate supervision when providing ADL care (activities of daily living) to an agitated and combative resident which resulted in a fall with a confusion and laceration to the head for 1 of 3 resident's reviewed for accidents (Resident #2). During the complaint survey of 3/16/2017 the facility was cited for accident (F 323). Based on observation, physician and staff interviews and record review, the facility failed to call for additional assistance, provide interventions for a resident with combative during care, and prevent an injury while providing care when Resident #1 was agitated, moving about in bed and struck her head on the side portion of the metal side rail. Resident #1 was sent out to the hospital after a change in condition was noted. A diagnosis of a subdural hematoma (brain bleed) and a hematoma was made at the hospital. This was one resident in a sample of three with accidents. The Administrator was interviewed on 4/29/2017 at 5:30 PM. His would expect that all staff would be re-educated again on combativeness and de-escalation and prevention. He stated that he would expect for QA to identify areas of concern and follow up with a plan of correction.	F 520	5/24/17. 3. The District Director of Clinical Services will randomly review QAPI minutes and attend meetings when possible. The QAPI committee will meet more frequently than the required quarterly meeting, meeting at least weekly x 4, then monthly x 3 months. The weekly meeting will focus on the requirements of the tag F323 (483.25 Free of Accident Hazards/Supervision/Devices) and the committee will develop an action plan for process improvements and deficiency correction as needed. 4. All results will be brought to QAPI x 3 months, or until no further issues noted.	