STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation of 6/9/2017. Event ID #IQ8Q11.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		7/7/17

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

Electronically Signed | 06/29/2017

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F 157	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the physician and nursing administration of the unavailability of ordered medications which resulted in missed medication doses for 1 of 5 residents (Resident #5). Findings included: Record review revealed Resident #5 was admitted to the facility on 1/10/2017 with diagnoses which included Gastroesophageal Reflux Disease (GERD, caused when gastric acids from the stomach go up into the esophagus) Chronic Pain and Hypertension. The most recent Minimum Data Set (MDS) dated 4/13/2017 indicated the resident was cognitively intact and was able to make her needs known. Review of the resident's care plan updated on 4/13/2017 included a risk for side effects of medications. One of the interventions listed on the care plan was to administer medications as	F 157	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1.Resident affected Resident # 5, the physician was notified and the medication was available on 5/16/17. 2.Residents with potential to be affected a.Review of all medication administration records by Nurse Manager / Licensed Nurse to identified residents with medications unavailable. The pharmacy	

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F 157	Continued From page 2 ordered by the physician. Review of the Resident's Physician's Progress notes revealed a Physician Visit note written on 5/1/2017. The note reported the resident had increased belching and reflux symptoms. The physician note indicated an additional medication for GERD symptoms would be added to the resident's medication regimen. A review of the Medication Administration Record (MAR) revealed the order for the medication was added on 5/2/2017 and was to be administered twice daily, the medication was stopped on 5/16/2017 due to a physician order to replace the medication with a different medication for GERD. Further review of the MAR revealed of the 30 doses of the medication ordered from 5/2/2017-5/16/2017, 8 doses were not administered. 7 of the dosed were circled and there was documentation for 5 of the circled medications as unavailable. There was no documentation for 3 of the circled missed doses. An interview was conducted with the Director of Nursing (DON) and the facility Nurse Consultant on 6/8/2017 at 9:31 AM. The DON reported she was unaware of any missed medications for Resident #5. The DON stated the pharmacy delivered medications before noon for refilled medications and also delivered in the evening. The facility Nurse Consultant indicated medications for the residents were always available and there was a back-up pharmacy in a neighboring town which was always (24 hours daily 7 days a week) for any medications needed for the residents. The DON stated the expectation was for medications to be administered as ordered. The DON further stated the expectation was to be notified if medications ordered were not	F 157	and/or back up pharmacy was notified for distribution of medications, if unavailable, the physician was notified for an alternative order. b.Process of securing the medication is, Physician orders is faxed to pharmacy, if the medication in unavailable from pharmacy then nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will contact the physician immediately for an alternative order. c.Medications that have an automatic therapeutic substitution, the pharmacy sends the therapeutic substitution order to the facility, the facility sends the order to the physician for a signature, the nurse transcribes the order onto the medication administration record, and pharmacy dispenses the medication. 3.Systemic Change/Interventions a.Licensed Nurse Education began on6/15/17 by the Interim Director of Health Services on procuring medications, therapeutic substitutions and Physician immediate notification if the medication is unavailable. Licensed Nurses not educated by July 7, 2017 will be removed from the schedule until their education is complete. b.Therapeutic substitutions, procuring medications and physician immediate notification if medication is unavailable has been added to the new partner orientation for licensed nurses.	

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F 157	Continued From page 3 available in the facility and the physician to be notified of missed medication doses. A telephone interview was conducted with the resident's facility physician on 6/8/2017 at 11:24 AM. The physician stated he was not notified of the resident's missed medications for GERD and stated he adjusted her medications for dyspepsia (upper abdominal pain or discomfort) due to continued symptoms. The physician stated he was sure the missed doses did not cause the resident any harm, but she definitely needed her medications to be administered consistently as ordered. The physician stated his expectation was to be notified of missed doses of medications, especially if there were multiple doses missed. A telephone interview was conducted with Nurse #4 on 6/8/2017 at 12:52 PM. Nurse #4 confirmed she was the nurse who circled the medications and documented they were unavailable. Nurse #4 stated she remembered the medication for the resident not being in the packet sent by the pharmacy for administration. Nurse #4 stated when medications were not available she reordered them by fax from the pharmacy. Nurse #4 stated she was sure the medications were reordered and did not know why they were not delivered. Nurse #4 stated she did not notify the DON or the physician of the medication unavailability for administration, and stated she guessed she just didn't think about letting anyone know the medication was not administered.	F 157	c.Upon admission the Physician orders are faxed to pharmacy, if the medication is unavailable from pharmacy the nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse immediately will contact the physician and obtain alternate order prior to the first scheduled dose. d.Medications that have an automatic therapeutic substitution, the pharmacy sends the therapeutic substitution order to the facility, the facility sends the order to the physician for a signature, the nurse transcribes the order onto the medication administration record, and pharmacy dispenses the medication. e.The Nurse Manager is validating the medication has been delivered and/or the physician has been contacted for alternate orders. This will occur daily for 7 days then weekly thereafter. 4.Plan to Monitor a.The Director of Health Services will present the findings of the Medication Availability / Physician Notification review to the Quality Assurance Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance has been maintained.	
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		7/7/17

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F 241	Continued From page 4 (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain dignity by staff failing to knock on doors or ask permission to enter resident's rooms for three of fifteen residents (Residents #68, #67 and #6). Findings included: A review of the medical record revealed Resident #68 was admitted on 3/3/2017 with diagnoses of sepsis, muscle weakness and Hypertension. The 14 day Minimum Data Set (MDS) dated 3/15/2017 noted Resident #68 to be cognitively intact. On 6/7/2017 at 3:45 PM, Nurse #1 was observed to enter Resident #68's room to administer medications. The Nurse failed to knock on the door or announce herself. A review of the medical record revealed Resident #67 was admitted 3/31/2017 with diagnoses of Generalized Anxiety Disorder, Hypertension and Diabetes. The Admission Minimum Data Set (MDS) dated 4/11/2017 noted Resident #67 was severely impaired for cognition. On 6/7/2017 at 4:10 PM, Nurse #1 was observed to enter Resident #67's room to administer medications. The Nurse failed to knock or announce herself. A review of the medical record revealed Resident	F 241	1.Residents affected a.No negative outcome noted for Resident #6, #67, and #68. 2.Residents with potential to be affected a.All residents have the potential to be affected. b.Education was provided by the facility Administrator regarding dignity for residents, with focus on employees knocking on doors or asking for permission to enter rooms. 3.Systemic Changes/Interventions a.On 6/15/17, the Administrator educated employees on knocking on doors and/or announcing self, prior to entering a resident room. Employees who have not attended the education by 7/7/17 will be removed from the schedule until education has been provided. b.Department Managers (Administrator, Interim Director of Health Services, Nurse Manager, Certified Dietary Manager, Case Mix Director, Social Service Director and/or Maintenance Director will observe	

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F 241	Continued From page 5 #6 was re-admitted 5/4/2017 with diagnoses of Chronic Kidney Disease Stage 4, GERD, and reflux. The Admission Minimum Data Set (MDS) dated 5/10/2017 noted Resident #6 was cognitively intact. On 6/7/2017 at 4:18 PM, Nurse #1 was observed entering Resident #6's room to administer medications. The Nurse failed to knock or announce herself. On 6/7/2017 at 4:20 PM, in an interview, Nurse #1 stated she did not know why she did not knock. Nurse #1 indicated she usually did knock and announce herself. In an interview on 6/7/2017 at 4:30 PM, the Director of Nursing stated the expectation was staff would always knock on resident's doors and announce themselves.	F 241	staff knocking on resident□s door and/or announcing themselves prior to entering the resident rooms, this will occur daily for 7 days, weekly for 3 weeks then monthly thereafter. c.The Administrator will correlate the observation forms daily to review tracking and trending of employees knocking/announcing themselves prior to entering the resident□s rooms. 4.Plan to monitor a.The Administrator will present the analysis of the Dignity (knocking and/or announcing prior to entering resident□s room) to the quality assurance Performance Improvement committee monthly until 3 months of continued compliance has been maintained.	
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 248		7/7/17

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F 248	Continued From page 6 Based on record review, observations, staff and family interviews, the facility failed to provide meaningful activities including 1:1 and group activities which resulted in a lack of activities to meet individual needs from 6/5/2017 through 6/9/2017 for 1 of 1 resident reviewed for activities (Resident #34). Findings included: Record review revealed resident #34 was admitted to the facility on 6/5/2014 with diagnoses which included Rickets (deformities of the long bones), Muscle Weakness and Chronic Kidney Disease. A significant change Comprehensive Minimum Data Set (MDS) dated 1/9/2017 indicated it was very important for the resident to do her favorite activities and participate in religious services or practices. The most recent Quarterly Minimum Data Set (MDS) dated 4/10/2017 revealed the resident was severely cognitively impaired and required total assistance with all activities of daily living. Record review of the care plan updated 4/10/2017 revealed the resident had a potential for social isolation related to impaired mobility. Interventions listed included activities would visit the resident so appropriate in room activities could be determined, resident's limited mobility would be accommodated for participation in activities outside of room and attendance at activities outside of room would be reinforced with verbal praise. The goal was the resident would participate in activities 2-4 times a week through the next review. An interview was conducted with the resident's	F 248	1.Residents affected a.Resident # 34 was provided 1:1 activities of choice. 2.Residents with the Potential to be affected a.Residents who do not attend group activities have the potential to be affected. b.The Activities Director has reviewed each Resident□s preferences for activities and has designed a participation program for each resident. 3.Systemic Changes a.The Activities Director will review each resident activities preference quarterly. b.The Administrator educated the Activities regarding accurate activity documentation with focus on active versus passive participation. c.The Administrator will review five residents□ activity participation logs weekly for three weeks then monthly thereafter, to ensure the participation in activities was documented accurately. d.The Administrator will review the Residents activity preferences completed by the activity director weekly for 4 weeks then monthly thereafter. 4.Plan to Monitor	

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F 248	Continued From page 7 family member on 6/5/2017 at 5:00 PM. The family member reported the resident did not participate in activities like she used to and stated she did not know why. The family member stated she was told the facility provided 1:1 activities with the resident but the resident used to get up in the reclining chair and attend out of room activities. The family member reported the facility recently completed some significant staff changes and thought that could have been a factor. The following observations were made of Resident #34 on: -6/5/2017 at 5:00 PM, the resident was in bed with a family member at the bedside -6/5/2017 at 6:00 PM, the resident was in bed with no observed activity -6/6/2017 at 8:30 AM, 9:45 AM, 10:40 AM, 12:10 PM, 1:40 PM, 3:15 PM, 4:45 PM and 5:30 PM, the resident was in bed during each observation with no observed activity -6/7/2017 at 8:15 AM, 10:00 AM, 11:45 AM, 12:30 PM, 2:00 PM, 3:30 PM, 5:00 PM and 5:45 PM, the resident was in bed during each observation with no observed activity -6/8/2017 at 8:30 AM, resident was in bed with no observed activity An interview was conducted with NA # 1 on 6/8/2017 at 8:59 AM. NA #1 reported she worked with the resident most of the time but there were days the resident was on another NA's assignment. NA #1 reported the resident was confused all the time. NA #1 stated she did not know why the resident did not attend activities and the NA did not get the resident up unless the nurse or someone told her the resident needed to be up. NA #1 stated she did not remember the	F 248	a.The Administrator will present the analysis of the activity participation logs to the Quality Assurance/Performance Improvement Committee for review and recommendation monthly until three consecutive months of compliance is sustained.	

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last time the resident went to an activity. NA #1 stated she did not remember seeing anyone in the resident's room doing activities.

The following observations were made of Resident #34 on:
-6/8/2017 at 9:45 AM,11:00 AM, 12:10 AM, 1:55 PM, 3:00 PM, 4:00 PM and 5:20 PM, the resident was in bed during each observation with no observed activity

An interview was conducted on 6/8/2017 at 5:36 PM with the facility Activity Director (AD).
The AD stated the resident loved music and she did invite the resident to activities. The AD stated she invited the resident to the religious singing group the day before and the resident didn't want to get up. The AD stated she provided 1:1 activities with the resident and thought she did a room activity with the resident on Monday. The AD stated she needed to think about it a moment to remember what activity was completed. The AD reported the resident liked books and she read some of a book to the resident on Monday and the AD stated she also put some lotion on the resident's hands during the visit. The AD stated she completed documentation for the visit on Monday. A copy of the documentation was requested and an Activity Log Report was printed from the AD's computer. The report was reviewed with the AD and observed to have the dates for the week with check boxes for the activities and the resident's participation level. On 6/8/2017 checks in the boxes for one to one, group, religion, socials, family/friends visit, actively participated, participated some and observed. The AD stated the resident did actively participate in the religious singing group activity because the resident could hear the music from her room, the

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F 248	Continued From page 9 AD stated if the resident was asleep she may not have participated. The AD further stated the resident participated in the social which occurred in the facility dayroom today because even though the resident was in bed in her room, the resident ate a cup of popcorn from the social and that was sensory stimulation. When asked if the AD stayed and visited the resident while she ate the popcorn, the AD stated she did not. The AD reported it was still considered participation because she was given the popcorn. When asked if the AD delivered the popcorn to the resident, the AD indicated she did not deliver it and thought an NA took the popcorn to the resident. An interview was conducted with the facility Administrator on 6/8/2017 at 5:52 PM. The Administer stated the expectation was for all residents to be provided ongoing activities. The Administrator further stated social activities for residents required a social setting with other residents or staff.	F 248		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain the door of a resident's bathroom in good working condition for one bathroom door (room 14), and the facility failed to repair a cabinet door in a shared bathroom (room 9). Findings included:	F 253	1.Resident affected a.The bathroom door (room #14) and the cabinet door (room # 9) was corrected on 6/9/2017 2.Residents with potential to be affected	7/7/17

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F 253	Continued From page 10 1. On 6/7/2017 at 9:20 AM, in room 14, the door into the bathroom was observed to have areas near the doorknob with missing wood around the latch. The lower part of the door also had an area with missing wood. There was a crack across the lower half of the door. On the inside the door, the metal door frame was rusted at the bottom of both sides. On the right lower side of the door, there was no frame from the floor to 6 inches above the floor and there were rusted, uneven, rough areas observed. A review of the medical record revealed Resident #66 was admitted 5/31/2017 with diagnoses of arthritis, anxiety and depression. The Admission Minimum Data Set (MDS) dated 6/7/2017 noted Resident #66 was cognitively intact and needed limited assistance for all Activities of Daily Living (ADLs) with the physical assistance of one person. On 6/7/2017 at 9:30 AM, in an interview, Resident #66 stated he was in the same room during a prior facility stay a year ago and the door had been broken and rusted at that time. 2. On 6/7/2017 at 9:45 AM, an observation was made of the bathroom shared by room 8 and room 9. Above the toilet attached to the wall was a single cabinet. The cabinet door was ajar and hanging at an angle, one side of the cabinet door being lower than the other side. The door was not secure and when opened hung loosely from the cabinet. There was also a cabinet above the bathtub with a door in the same condition. On 6/7/2017 at 4:40 PM, in an interview, the Maintenance Director stated all of the rooms in	F 253	a.All resident rooms have the potential to be affected. b.The Maintenance Director reviewed all resident cabinets and bathroom doors on 6/9/2017 with identified areas corrected. 3.Systemic Changes a.On 6/15/17, the Administrator educated the employees on the use of Building Engines and/or the maintenance workbook for reporting items needing repair. b.The Administrator and/or Maintenance Director will make facility rounds weekly (including rooms and bathrooms) to identify new areas requiring repair and the areas already identified have been corrected. c.The Administrator and/or Maintenance Director will track and trend areas of repair weekly for 4 weeks then monthly thereafter. 4.Plan to Monitor b.The Administrator will present the analysis of the areas needing repair to the Quality Assurance/Performance Improvement Committee for review and recommendation monthly until three consecutive months of compliance is sustained.	

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F 253	Continued From page 11	F 253		

the facility were checked once per month. The Maintenance Director indicated the computer showed each day which rooms would be checked and if the inspections were not done, the computer would flag those areas and the report would be sent to the Administrator and the corporate office.

On 6/7/2017 at 4:55 PM, the door into the bathroom in room 14 was observed to be closed. The Maintenance Director tried to open the door but was unable to on the first attempt. The Director stated the door was stuck because it had settled. The Maintenance Director pulled the door again and forced the door open. When the areas of damage to the door were pointed out, the Maintenance Director stated "I can fix all that". When the Director was asked why the door was not seen during the monthly inspections, the Maintenance Director responded "I just missed it".

On 6/7/2017 at 5:05 PM, the Maintenance Director was present during an observation in the shared bathroom between room 8 and room 9. The Maintenance Director stated the Nursing Assistants (NAs) did not put the residents' wash basins in the cabinets correctly and the cabinets would not shut properly. When it was pointed out the cabinet doors were crooked and loose, the Maintenance Director stated "the screws are loose, that can be fixed". The Maintenance Director stated he just missed the crooked, loose doors in the monthly inspection.

A review of the printout of the Maintenance Director's daily checklist revealed items to be checked, but did not list any rooms.
On 6/7/2017 at 5:10 PM, in an interview, the

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F 253	Continued From page 12 Administrator stated his expectation would be the Maintenance Director would keep the facility in generally good repair.	F 253		
F 280 SS=E	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 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		7/7/17

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(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 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.

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F 280	Continued From page 14 (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 staff interviews and record review, the facility failed to ensure a nursing assistant participated with the development and/or revision of the care plan during the interdisciplinary care team planning for 10 of 10 residents reviewed (Resident #73, Resident #11, Resident #2, Resident #9, Resident #34, Resident #22, Resident #5, Resident #69, Resident #42 and Resident #90). Findings included: 1. Record review of Resident #73 revealed admission to the facility on 3/6/2017 with diagnoses which included Diabetes and Hypertension. Review of the resident's care plan indicated a care plan review was conducted on 3/21/2017 and consisted of nursing, dietary, social services and activities. . An interview was conducted with the Minimum Data Set (MDS) Coordinator Registered Nurse (RN) on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and	F 280	1.Residents affected a.The Case Mix Coordinator and Nursing Assistant reviewed Resident #73, #11, #2, #9, #34, #22, #5, #69, #42 and #90 care plans for development and/or revision on 6/28/2017. 2.Residents with the potential to be affected a.All Residents have the potential to be affected. b.A Nursing Assistant began participating in the development and/or revision of the Residents care plan on 6/27/2017. 3.Systemic Changes a.The Case Mix Coordinator was educated on 6/9/2017 by the Administrator, regarding nursing assistance participating in the care planning process. b.The Case Mix Coordinator will invite the nursing assistant to participate in the care planning process of residents and maintain a signature sheet of participation.	

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F 280	Continued From page 15 therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. 2. Record review of Resident #11 revealed admission to the facility on 2/16/2011 with diagnoses which included Cellulitis and Morbid Obesity. Review of the resident's care plan indicated a care plan review was conducted on 3/28/2017 and consisted of nursing, dietary, social services and activities. . . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. 3. Record review of Resident #2 revealed admission to the facility on 5/17/2016 with diagnoses which included Hypertension and	F 280	c.The Administrator will track and trend the care plan schedule with the care plan signature sheets weekly for 4 weeks, monthly for 3 months, to ensure the nursing assistants are participating in the process. 4.Plan to Monitor a.The Administrator will present the analysis of the nursing assistants participating in care planning to the Quality Assurance/Performance Improvement Committee for review and recommendation monthly until three consecutive months of compliance is sustained.	

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F 280	Continued From page 16 Muscle Weakness. Review of the resident's care plan indicated a care plan review was conducted on 3/28/2017 and consisted of nursing, dietary, social services and activities. . . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. 4. Record review of Resident #9 revealed admission to the facility on 2/15/2013 with diagnoses which included Hypertension and Diabetes. Review of the resident's care plan indicated a care plan review was conducted on 4/10/2017 and consisted of nursing, dietary, social services and activities. . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions	F 280		

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F 280	Continued From page 17	F 280		

or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin.

5. Record review of Resident #34 revealed admission to the facility on 6/5/2014 with diagnoses which included Chronic Kidney Disease and Dyspepsia. Review of the resident's care plan indicated a care plan review was conducted on 4/11/2017 and consisted of nursing, dietary, social services and activities.
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An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin.

6. Record review of Resident #22 revealed admission to the facility on 8/8/2016 with diagnoses which included Hypertension and Diabetes. Review of the resident's care plan indicated a care plan review was conducted on

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F 280	Continued From page 18 4/11/2017 and consisted of nursing, dietary, social services and activities. . . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. 7. Record review of Resident #5 revealed admission to the facility on 1/10/2017 with diagnoses which included Hypertension and Osteoarthritis. Review of the resident's care plan indicated a care plan review was conducted on 4/17/2017 and consisted of nursing, dietary, social services and activities. . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN	F 280		

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stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin.

8. Record review of Resident #69 revealed admission to the facility on 1/26/2017 with diagnoses which included Diabetes and Multiple Sclerosis. Review of the resident's care plan indicated a care plan review was conducted on 5/2/2017 and consisted of nursing, dietary, social services and activities.
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An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin.

9. Record review of Resident #42 revealed admission to the facility on 7/14/2014 with diagnoses which included Dementia and Muscle Weakness. Review of the resident's care plan indicated a care plan review was conducted on

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F 280	Continued From page 20 4/25/2017 and consisted of nursing, dietary, social services and activities. . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. 10. Record review of Resident #90 revealed admission to the facility on 4/28/2017 with diagnoses which included Heart Disease and Insomnia. Review of the resident's care plan indicated a care plan review was conducted on 5/12/2017 and consisted of nursing, dietary, social services and activities. . . An interview was conducted with the MDS RN on 6/9/2017 at 8:45 AM. The MDS RN reported attendance for the interdisciplinary care plan meetings consisted of an RN, a dietary representative, Social Worker, activities, the resident or a resident's responsible party and therapy would attend if there were any questions or concerns with their disciplines. The MDS RN	F 280		

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F 280	Continued From page 21 stated nursing assistants did not attend the meetings and prior to a conference call she participated in yesterday, she was unaware nursing assistants were required to attend. The MDS RN indicated the facility was starting the new process for the care plan meetings, but was not sure when it would begin. An interview was conducted with the Director of Nursing (DON) and the Facility Nurse Consultant on 6/9/2017 at 11:30 AM. The DON indicated she was unaware a nursing assistant needed to be present in the care plan meetings. The Facility Nurse Consultant stated the expectation was for the nursing assistant regularly assigned to the resident be present in the meeting so they could give input regarding the resident's condition and care.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to administer medications as ordered, which resulted in missed medication doses for 1 of 5 residents (Resident #5). Findings included:	F 281	1.Resident affected Resident # 5, the physician was notified and the medication was available on 5/16/17 2.Residents with potential to be affected	7/7/17

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F 281	Continued From page 22 Record review revealed Resident #5 was admitted to the facility on 1/10/2017 with diagnoses which included Gastroesophageal Reflux Disease (GERD, caused when gastric acids from the stomach go up into the esophagus) Chronic Pain and Hypertension. The most recent Minimum Data Set (MDS) dated 4/13/2017 indicated the resident was cognitively intact and was able to make her needs known. Review of the resident's care plan updated on 4/13/2017 included a risk for side effects of medications. One of the interventions listed on the care plan was to administer medications as ordered by the physician. Review of the Resident's Physician's Progress notes revealed a Physician Visit note written on 5/1/2017. The note reported the resident had increased belching and reflux symptoms. The physician note indicated an additional medication for GERD symptoms would be added to the resident's medication regimen. A review of the Medication Administration Record (MAR) revealed the order for the medication was added on 5/2/2017 and was to be administered twice daily, the medication was stopped on 5/16/2017 due to a physician order to replace the medication with a different medication for GERD. Further review of the MAR revealed of the 30 doses of the medication ordered from 5/2/2017-5/16/2017, 8 doses were not administered. 7 of the dosed were circled and there was documentation for 5 of the circled medications as unavailable. There was no documentation for 3 of the circled missed doses. An interview was conducted with the Director of Nursing (DON) and the facility Nurse Consultant on 6/8/2017 at 9:31 AM. The DON reported she	F 281	a.Review of all medication administration records identified by Nurse Manager / Licensed Nurse to identified residents with medications. The pharmacy and/or back up pharmacy was notified for distribution of medications, if unavailable, the physician was notified for an alternative order. b.Process of securing the medication is, Physician orders is faxed to pharmacy, if the medication in unavailable from pharmacy then nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse will contact the physician immediately for an alternative order. c.Medications that have an automatic therapeutic substitution, the pharmacy sends the therapeutic substitution order to the facility, the facility sends the order to the physician for a signature, the nurse transcribes the order onto the medication administration record, and pharmacy dispenses the medication. 3.Systemic Change/Interventions a.Licensed Nurse Education began on6/15/17 by the Interim Director of Health Services on procuring medications, therapeutic substitutions and Physician immediate notification if the medication is unavailable. Licensed Nurses not educated by July 7, 2017 will be removed from the schedule until their education is complete.	

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F 281	Continued From page 23 was unaware of any missed medications for Resident #5. The DON stated the pharmacy delivered medications before noon for refilled medications and also delivered in the evening. The facility Nurse Consultant indicated medications for the residents were always available and there was a back-up pharmacy in a neighboring town which was always (24 hours daily 7 days a week) for any medications needed for the residents. The DON stated the expectation was for medications to be administered as ordered. A telephone interview was conducted with the resident's facility physician on 6/8/2017 at 11:24 AM. The physician stated he was not notified of the resident's missed medications for GERD and stated he adjusted her medications for dyspepsia (upper abdominal pain or discomfort) due to continued symptoms. The physician stated he was sure the missed doses did not cause the resident any harm, but she definitely needed her medications to be administered consistently as ordered. The physician stated his expectation was medications for residents would be administered as ordered. A telephone interview was conducted with Nurse #4 on 6/8/2017 at 12:52 PM. Nurse #4 confirmed she was the nurse who circled the medications and documented they were unavailable. Nurse #4 stated she remembered the medication for the resident not being in the packet sent by the pharmacy for administration. Nurse #4 stated when medications were not available she reordered them by fax from the pharmacy. Nurse #4 stated she was sure the medications were reordered and did not know why they were not delivered. Nurse #4 stated she did not notify the	F 281	b.Therapeutic substitutions, procuring medications and physician immediate notification if medication is unavailable has been added to the new partner orientation for licensed nurses. c.Upon admission the Physician orders are faxed to pharmacy, if the medication is unavailable from pharmacy the nurse calls the backup pharmacy, when medication is unavailable from the backup pharmacy the nurse immediately will contact the physician and obtain alternate order prior to the first scheduled dose. d.Medications that have an automatic therapeutic substitution, the pharmacy sends the therapeutic substitution order to the facility, the facility sends the order to the physician for a signature, the nurse transcribes the order onto the medication administration record, and pharmacy dispenses the medication. e.The Nurse Manager is validating the medication has been delivered and/or the physician has been contacted for alternate orders. This will occur daily for 7 days then weekly thereafter. 4.Plan to Monitor a.The Director of Health Services will present the findings of the Medication Availability / Physician Notification review to the Quality Assurance Performance Improvement committee for review and recommendations monthly until three	

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F 281	Continued From page 24 DON or the physician of the medication unavailability for administration, and stated she guessed she just didn't think about letting anyone know the medication was not administered.	F 281	consecutive months of compliance is sustained.	
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 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 record review, observations and staff, resident and physician interviews, the facility failed to investigate contributing factors to falls and failed to implement fall interventions to	F 323	1.Residents affected a.Review and investigation of resident #5 falls was completed on 6/27/17 and	7/7/17

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F 323	Continued From page 25 minimize the potential for further accidents, which resulted in an increased risk for recurrent falls for 1 of 3 residents (Resident # 5). Findings included: Record review revealed Resident #5 was admitted to the facility on 1/10/2017 with diagnoses which included Chronic Pain, Hypertension and Repeated Falls. The Admission Care Area Assessment (CAA) dated 1/18/2017 revealed the resident was able to make her needs known and the resident reported a history of falls prior to facility admission. The CAA further revealed the resident was at a risk for further falls and the area would proceed to the care plan. The most recent Quarterly Minimum Data Set (MDS) dated 4/13/2017 indicated the resident was cognitively intact and was not steady when moving from a seated to standing position without staff assistance. The MDS further indicated the resident required a wheelchair or walker for mobility. The care plan initiated on admission and updated on 4/13/2017 listed falls as an area of care concern for the resident. Fall interventions listed were to keep the walker or wheelchair in the resident's reach at all times, remind the resident to ask for assist with transfers and ambulation, monitor for changes in the resident's condition and to notify the physician with changes and to assist the resident for all ambulation. The goal was the resident would not experience any injury related to falls. No additional fall interventions were listed after 4/13/2017. Record review of the Facility Incident Log revealed Resident #5 sustained falls on 5/1/2017, 5/7/2017 and 5/30/2017. Record review revealed a Post-Incident Action form dated 5/1/2017 at 1:30 PM and completed by Nurse #1 was observed in the medical record. The Post-Incident Action form's narrative	F 323	interventions have been put into place to minimize to potential for further accidents. 2.Resident with the Potential to be affected. a.All residents have the potential to be affected. b.The Nurse Managers have reviewed Resident□s with falls for investigation of contributing factors and implementation of interventions to minimize the potential for further accidents. 3.Systemic Changes a.On 6/15/17, the Interim Director of Nurses began educating the Licensed Nurses on investigating contributing factor to falls and implementing interventions to minimize the potential for further accidents. Licensed staff who has not attended the educated by 7/6/17 will be removed from the schedule until education has occurred. b.The Interim Director of Nursing will review event reports including investigations forms within 24 hours of the event to complete the investigation form and ensure the implementation of interventions has occurred. c.The Interim Director of Nursing will track and trend the use of investigation reports and implementation of interventions daily for 7 days then weekly thereafter.	

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F 323	Continued From page 26 description indicated the resident was returning to bed after she utilized the bed side commode when she fell to the floor. The form listed the Immediate Action taken was an assessment was completed and the resident was assisted back to bed. The form listed the immediate Post-Incident Action taken was the bedside commode was placed closer to the resident. A Neurological Observation Form initiated by Nurse #1 and dated 5/1/2017 with the initial assessment at 1:35 PM was in the medical record. Neurological assessments were conducted for the next 36 hours. There were no negative observations documented in the assessments. A faxed physician notification of the fall dated 5/1/2017 at 1:40 PM was in the medical record. The notification was completed by Nurse #1 and reported the resident fell at bedside with no observable injuries noted and neurological (neuro) checks were initiated. The physician's initials were on the notification form indicating he reviewed the fax. Record review revealed a Situation, Background, Appearance, Review and Notify (SBAR) Communication Form and Progress Note form completed by Nurse #2 and dated 5/7/2017 at 1:50 PM, revealed the resident sustained an unobserved fall and was found on the floor in her room. The documentation revealed the resident reported she hit her head on the back of the wheelchair when she fell. The note indicated there was a small knot on the back of the resident's head. The MD was notified and ordered to send the resident to the Emergency Department (ED) to be evaluated. There was no additional nursing notes in the medical record on 5/7/2017 which pertained to the fall. A nursing note dated 5/8/2017 at 9:45 AM by Nurse #1 reported the resident was alert and oriented with	F 323	4.Plan to Monitor a.The Interim Director of Nursing will present the analysis of the investigation reports and implementation of interventions to the Quality Assurance Performance Improvement committee for review and recommendations monthly until three consecutive months of compliance is sustained.	

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no reported issues from the recent fall. The note further indicated the resident was sent to the ED post fall and returned with no new orders.
A nursing note dated 5/30/2017 at 12:10 PM by Nurse #3 revealed the resident attempted to get up unassisted and fell to the floor. The note indicated the resident complained of some pain under the right breast area. The MD was notified and ordered an x-ray of the area. The x-ray was completed in the facility and documentation of the original report indicated no acute findings, but there was indication of old fractures to the ribs on the right side. The report was called to the physician at 2:45 PM by Nurse #3. A nursing note dated 5/30/2017 at 11:30 PM by Nurse #4 indicated notification from the radiologist reported some of the fractures reviewed on the x-ray may have been new and for the resident to stay in bed until she could be seen by her primary physician and if her pain increased or condition worsened to send her to the ED.
A physician progress note dated 5/31/2017 revealed the physician assessed the resident that morning and the resident was at her baseline condition. There were no bruises noted to the rib area and the resident had no issues in her respiratory status. The note further revealed the physician discussed the resident's condition with the nursing staff and since the resident received scheduled pain medication and an order for pain medication as needed was in effect, no new orders or changes were indicated.
There were no further nursing notes which indicated the resident was in pain or had any condition changes related to the fall.
An observation and interview was conducted with the resident on 6/6/2017 at 9:12 AM. The resident was very well kept and sitting on the side of the bed. The resident's bed was in a low position and

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her wheelchair was observed beside the bed. The resident indicated she remembered the times she sat on the floor but she didn't really consider them falls. The resident stated she did not like to think about falls, and she had some pretty bad falls prior to admission to the facility. The resident further stated when she lost her balance she would fall a little and perhaps that is what she did. The resident recalled the physician mentioned an x-ray revealed some rib fractures but she had fractured her ribs at home and the pain from the last fall did not compare. The resident reported she thought the fractures on the x-ray were the old ones because the area was only a little sore for an hour or so and she didn't have any bruises. The resident stated she understood she needed to call for assistance but she did not like to do that sometimes.

An interview was conducted with the resident's facility physician on 6/8/2017 at 11:25 AM. The physician stated he was aware of the resident's falls and he was also aware the resident would not call for assist at times. The physician stated the expectation for any resident fall would be for the fall to be investigated and appropriate interventions implemented.

An interview was conducted with Nurse #1 on 6/8/2017 at 1:30 PM. Nurse #1 reported she was the nurse for Resident #5 Monday through Friday on the day shift. Nurse #1 indicated she remembered the falls on 5/1/2017, 5/7/2017 and 5/30/2017. Nurse #1 stated the process when a resident falls was to ensure the resident was safe, complete an assessment and start neuro checks. Nurse #1 stated the physician and the responsible party were notified and documentation of the incident needed to be completed. Nurse #1 indicated there were a lot of changes in administration and staff at the facility

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and she was still learning what had changed and the new processes. She stated she did not update a care plan and did not know much about where the interventions needed to be documented. Nurse #1 revealed she remembered the resident had long oxygen tubing and she shortened it because maybe the tubing made the resident fall, but the resident didn't use oxygen anymore. Nurse #1 indicated she thought there was a fall mat at one time and it was removed because another resident needed one and Resident #5 had difficulty with the wheelchair on the mat. Nurse #1 stated the resident's bed was always in the low position. Nurse #1 also stated she reinforced and reeducated the resident every day to call for assist but did not document the education. Nurse #1 further stated if anything was initiated for safety during the shift she reported it to the on-coming nurse at shift change.

Nurse #2 and Nurse # 3 were unavailable for interview.

An interview was conducted with the Director of Nursing (DON) on 6/8/2017 at 2:43 PM. The DON stated she was told it was the nurse's responsibility to initiate interventions when falls occurred. The facility Nurse Consultant was present during the interview and stated under normal circumstances the falls were reviewed and the causative factors for the fall were investigated and appropriate interventions were implemented. The Nurse Consultant and the DON reported many recent core staff changes which affected the monitoring and follow up systems for the facility. The DON indicated the falls were discussed in the daily morning meeting so interventions were implemented, but the meeting had just been initiated in the last week. The DON reported she did not review the falls

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F 323	Continued From page 30 prior to the initiation of the meeting last week. The DON stated the expectation was all falls in the facility would be care planned, reviewed and resident specific appropriate interventions would be implemented to promote the resident's safety and reduce falls.	F 323		