STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 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. (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	F 157		6/16/17

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

Electronically Signed | 06/16/2017

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F 157	Continued From page 1 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 observation, record reviews, physician and staff interviews the facility failed to notify the physician of a non-pressure wound on the resident's right heel for 1 of 1 residents sampled (Resident #166). The findings included: Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: methicillin resistant staphylococcus aureus (MRSA) septicemia, acute pulmonary embolism, decubitus ulcer of sacral region stage 2 present on admission, diabetic ulcer of right great toe, pressure ulcer of thigh stage 3 present on admission, and diabetes mellitus. Review of Initial Nursing Assessment dated 05/16/17 read in part, there was 5 small ulcers between left and right buttock. No other ulcers were identified on the initial nursing assessment. Review of a physician progress note dated 05/17/17 read in part, "Stage 3 decubitus to thigh and sacral decubitus. Wound doctor to see on Friday (05/19/17). The report did not reference a right heel wound.	F 157	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC). Corrective Action: Resident #166. Physician was notified on 5/24/17. New physician orders placed and initiated as ordered. Care plan updated. Resident and Resident's representative notified on 5/24/17. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified,	

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F 157	Continued From page 2 Review of the Wound Care Specialist Initial Evaluation dated 05/19/17 read in part, wound of the right posterior ankle was healing and surgical excisional debridement of the site was performed. The recommended treatment was Santyl (medicated ointment) once daily. An observation of wound care was made on 05/22/17 at 4:06 PM with Nurse #2. Nurse #2 was observed to apply wound dressing that contained Santyl to Resident #266's right and left back of thigh/buttock area. Nurse #2 was observed to also apply a wound dressing that contained Santyl to Resident #266's right heel. An interview was conducted with Nurse #7 on 05/24/17 at 2:53 PM. Nurse #7 confirmed that she was the nurse that admitted Resident #266 on 05/16/17 and completed the initial skin assessment. Nurse #7 stated that Resident #266's right foot was wrapped with a dressing and she did not remove the dressing and does not know what kind of ulcers were present under the dressing on admission. Nurse #7 stated the other foot was fine and had no ulcers. Nurse #7 was not aware of any ulcers on the right heel because she had not removed the dressing to visualize what was under it. An interview with the Medial Doctor (MD) was conducted on 05/24/17 at 3:08 PM. The MD confirmed that he had seen Resident #266 on 05/17/17 and was made aware of the wound to Resident #266's right great toe and to her thigh/buttock area. He added, that up to the time of this interview, he was not aware of any heel wound that Resident #266 had. The MD stated that when he visited Resident #266 on 05/17/17 her foot was dressed and he did not unwrap it to	F 157	and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that the facility must immediately inform the resident; consult with the resident's physician; and notify consistent with his or her authority, the resident's representative(s) when there is, an accident involving the resident which results in injury and has the potential for requiring physician intervention; A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); The facility must ensure that all pertinent information is available and provided upon request to the physician. The facility must ensure to notify the resident and the resident's representative when there is a change in room or roommate assignment, a change	

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F 157	Continued From page 3 visualize it. He added the dressing was clean and dry. The MD indicated that the Assistant Director of Nursing (ADON) had rounded with him and informed him of the right great toe wound and the wound to thigh/buttock area but he could not recall being informed of any heel wound that Resident #266 had. The MD stated that if he was notified of any wound he would go and see the wound. An interview with the ADON was conducted on 05/25/17 at 10:46 AM. The Director of Nursing (DON) was present during the interview. The ADON stated that he had rounded with the MD on 05/17/17 and he notified the MD of Resident #266's wounds. The ADON added that the MD had visualized the wounds on 05/17/17 but could not say for sure that he had visualized the wound to Resident #266's right heel, he added "I may have already placed the dressing on the foot and he may not have seen the wound that day." The ADON stated that at that meeting the MD should have been made aware of all the wounds that Resident #266 had including the right heel wound. The DON added that she expected that the MD to be made aware of all Resident #266's wound including the right heel wound.	F 157	in resident rights under Federal or State law or regulations and also the facility must ensure that there is a record and periodically update the address and phone number of the resident's representative. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to follow Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor	

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F 157	Continued From page 4	F 157	compliance by reviewing 5 residents' with non-pressure or pressure wounds weekly to ensure that physician has been notified and orders are followed and initiated as ordered. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _Jun 16th, 2017_____	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and	F 224		6/16/17

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F 224	Continued From page 5 exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations record review, and staff interview the facility neglected to initiate treatment orders on admission for a stage 3 pressure ulcer and neglected to initiate treatment to a non-pressure wound on the right heel for 8 days for 1 of 1 sampled resident (Resident #266). The resident was admitted with a Stage 3 pressure ulcer to the thigh/buttock area and treatment was not initiated for 3 day. The resident was also admitted with a non-pressure wound to the right heel and did not initiate treatment for 8 days. The findings included: a. Review of Resident #266's discharge summary from the hospital dated 05/16/17 read in part, decubitus ulcer of the sacrum stage 2/pressure ulcer of the thigh stage 3 present on admission. Wound care nurse to manage. Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: pressure ulcer stage 3, diabetes mellitus, hypertension, hyperlipidemia, and methicillin resistant staphylococcus aureus (MRSA) of unspecified site. Review of Initial Nursing Assessment dated 05/16/17 read in part, there was 5 small ulcers	F 224	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION. Corrective Action: Resident #266. Physician was notified on 5/24/17. New physician orders placed and initiated as ordered. Care plan updated. Resident and Resident's representative notified on 5/24/17. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified,	

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F 224	Continued From page 6 between left and right buttock. Review of a physician progress note dated 05/17/17 read in part, stage 3 decubitus to thigh and sacral decubitus. Wound doctor to see on Friday (05/19/17) and encourage resident to stay on side as much as possible. Review of the Wound Care Specialist's Initial Evaluation dated 05/19/17 read in part, Stage 3 pressure wound of the left buttock was pressure ulcer in etiology and the recommended treatment was Santyl (medicated ointment) once daily. Review of physician order dated 05/19/17 read, santyl to buttocks/sacral area every other day after cleaning with wound cleaner for wound care. An observation of Nurse #2 was made on 05/22/17 at 4:06 PM performing wound care on Resident #266. Nurse #2 was observed to apply a wound dressing that contained Santyl to Resident #266's left buttock/thigh area and then applied a cover to hold the santyl dressing in place. Review of the Medication Administration Record (MAR) dated 05/01/17 through 05/31/17 read in part, santyl ointment to buttocks/thigh topically every other day for wound care. This was initialed on 05/19/17, 05/21/17, and 05/23/17 indicating that the treatment had been completed on those days. The most recent comprehensive minimum data set (MDS) dated 05/23/17 remained in progress. An interview with the Assistant Director of Nursing (ADON) was conducted on 05/24/17 at 10:00 AM. The ADON confirmed that he was in charge	F 224	and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, Establish policies and procedures to investigate any such allegations including training. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at each nurse's	

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F 224	Continued From page 7 of managing wounds in the facility. He stated that when Resident #266 was admitted to the facility the staff should have implemented some type of treatment orders and he would have followed up the next day to make sure the treatment was appropriate. The ADON stated that no wound orders were transcribed from the hospital and they should have been. An interview with Nurse #7 was conducted on 05/24/17 at 2:53 PM. Nurse #7 confirmed that she had admitted Resident #266 to the facility and did complete the skin assessment. Nurse #7 stated that when Resident #266 admitted from the hospital she had no wound care orders and "I did not initiate any." She added that she did put in a referral to the wound nurse to assess her in the morning. Nurse #7 stated that if she discovered a pressure ulcer she generally would put an order for the wound nurse to assess and then cover the pressure ulcer with dry dressing. An interview with the Director of Nursing (DON) was conducted on 05/25/17 at 10:46 AM. The DON stated that she expected Nurse #7 to initiate some kind of wound care for Resident #266's wound on admission in addition to notifying the wound nurse that he needed to follow up. b. Review of the Wound Care Specialist Initial Evaluation dated 05/19/17 read in part, wound of the right posterior ankle was healing and surgical excisional debridement of the site was performed. The recommended treatment was santyl once daily. Review of physician order summary dated 05/01/17 through 05/23/17 revealed no physician order for a treatment to Resident #266's right heel	F 224	station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with pressure or non-pressure wounds weekly to ensure that physician was notified, orders are followed and initiated as ordered. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator	

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F 224	Continued From page 8 wound. An observation of wound care was made on 05/22/17 at 4:06 PM with Nurse #2. Nurse #2 was observed to apply a wound dressing that contained Santyl (medicated ointment) to Resident #266's right heel. An interview was conducted with the Assistant Director of Nursing (ADON) on 05/24/17 at 2:22 PM. The ADON stated that Resident #266 did a have ulcer to the right heel on admission and the treatment for it was santyl. He added that it had been draining Serosanguineous fluid since admission. The ADON indicated that he "just forgot about the wound to Resident #266's right heel." Review of a physician order dated 05/24/17 read in part, clean wound to right heel with wound cleaner and apply santyl and cover with maxorb and dry dressing every other day. An interview was conducted with Nurse #7 on 05/24/17 at 2:53 PM. Nurse #7 confirmed that she was the nurse that admitted Resident #266 on 05/16/17 and completed her initial skin assessment. Nurse #7 stated that Resident #266's right foot was wrapped with a dressing and she did not remove the dressing and does not know what kind of ulcer ' s were present under the dressing on admission. Nurse #7 stated that when Resident #266 admitted from the hospital she had no wound care orders and "I did not initiate any." She added that she did put in a referral to the wound nurse to assess her in the morning. Nurse #7 stated that if she discovered a wound she generally would put an order for the wound nurse to assess and then cover the	F 224	for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017_____	

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F 224	Continued From page 9 pressure ulcer with dry dressing. An interview with the Director of Nursing was conducted on 05/25/17 at 10:00 AM. The DON stated that Nurse #7 should have removed the routine dressing from Resident #266's right foot to visualize what was under the dressing and documented it in the medical record. She added if there was a wound under the dressing then Nurse #7 should have initiated some type of wound care treatment in addition to notifying the ADON.	F 224		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		6/16/17

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F 278	Continued From page 10 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for active diagnoses (Resident #15 and #176), dental status (Resident #272 and 273) and the use of a prosthetic device (Resident #273). Coding errors were discovered for 4 of the 19 sampled residents reviewed for MDS accuracy. The findings included: 1. Resident #15 was admitted to the facility on 06/09/2014. The psychiatric consult notes dated 2/6/17, specified the resident had diagnoses including depression and unspecified psychosis. Record review revealed the most recent assessment was a quarterly MDS dated 03/14/17. The MDS coding indicated the resident received antipsychotic and antidepressant medications on 7 out of the 7 days during the look back period. The MDS was also coded to reflect depression as an active diagnosis but it did not include psychosis. A review of Resident #15's March 2017 Medication Administration Record (MAR) revealed the resident received an antidepressant	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Corrective Action: Resident #15 A Modification Request was created for the OBRA Quarterly Assessment with the Assessment Reference Date of 3/14/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 6/10/2017 and includes the corrected record. Item I5950 has a value of Yes, indicating a modification request.	

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F 278	Continued From page 11 medication and also received Seroquel 100mg at bedtime (an antipsychotic) during the assessment period for the MDS dated 03/14/17. MDS Coordinator #1 was interviewed on 05/25/17 at 9:48 AM. MDS Coordinator #1 stated that when coding the active diagnoses, she would refer to the Medical Diagnoses section of the electronic record. The psychiatric consult notes were maintained in the physical chart kept at the nursing station. The MDS Coordinator said she didn't usually refer to the physical chart when coding diagnoses. During an interview on 05/25/17 at 3:20 PM, the Administrator stated she would expect the MDS assessments to be coded accurately. 2. Resident #176 was admitted to the facility on 07/21/16. The psychiatric consult notes dated 04/28/17, specified the resident had diagnoses including depression. Record review revealed the most recent assessment was a quarterly MDS dated 05/05/17. The MDS coding indicated the resident received an antidepressant medication on 7 out of the 7 days during the look back period. The MDS listed active diagnoses for the resident but the list did not include the diagnosis of depression. A review of Resident #176's May 2017 Medication Administration Record (MAR) revealed the resident received an antidepressant medication during the assessment period of the MDS dated 05/05/17.	F 278	The Modification Request was submitted to the QIES ASAP system on 6/12/2017 Resident #176 A Modification Request was created for the OBRA Quarterly Assessment with the Assessment Reference Date of 5/5/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 6/10/2017 and includes the corrected record. Item I5800 has a value of Yes, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 6/12/2017 Resident # 273 A Modification Request was created for the OBRA Admission Assessment with the Assessment Reference Date of 5/19/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were completed on 5/24/2017 and includes the corrected record. Item G0600D has a value of Yes, Item L0200B has a value of No and Item L0200Z has a value of Yes, indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 5/26/2017 Resident #272 A Modification Request was created for the OBRA Admission Assessment with the Assessment Reference Date of 5/16/2017. This corrected record has all items included, not just the items in error. The Correction Request Section X items were	

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F 278	Continued From page 12 MDS Coordinator #1 was interviewed on 05/25/2017 at 9:48 AM. MDS Coordinator #1 stated that when coding the active diagnoses, she would refer to the Medical Diagnoses section of the electronic record. The psychiatric consult notes were maintained in the physical chart kept at the nursing station. The MDS Coordinator said she didn't usually refer to the physical chart when coding diagnoses. During an interview on 05/25/2017 at 3:20 PM, the Administrator stated she would expect the MDS assessments to be coded accurately. 3. Resident #273 was admitted to the facility on 05/12/17 with diagnoses of diabetes mellitus, hypertension, hydronephrosis, acquired absence of right leg, acquired absence of left toes, anxiety, hyperlipidemia, and others. Review of the most recent comprehensive minimum data set (MDS) dated 05/19/17 revealed that Resident #273 was cognitively intact and required extensive assistance with activities of daily living (ADL). The MDS also indicated that Resident #273 was edentulous (having no teeth or tooth fragments), and the use of limb prosthesis was not identified. Review of the Dental Care Area Assessment (CAA) dated 05/22/17 read in part, Resident #273 had an upper partial and would proceed to the care plan. An observation and interview was conducted with Nursing Assistant (NA) #2 on 05/24/17 at 9:35 AM. Resident #273 was up in her wheel chair in her room and NA #2 was assisting her with ADL care. Resident #273 was noted to have natural teeth and she told NA #2 she wanted to brush her	F 278	completed on 5/24/2017 and includes the corrected record. Item L0200Z has a value of Yes, and Item L0200B has a value of No indicating a modification request. The Modification Request was submitted to the QIES ASAP system on 5/26/2017 Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. All assessments within the last 6 months were reviewed for accuracy for Item Set I5950, I5800, G0600D, L0200B and L0200Z by 6/12/2017 by the RN MDS coordinators. Systemic Changes: On 5/24/2017 The RN MDS Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Cooperate MDS Nurse Consultant. The education focused on the Federal regulations at 42 CFR 483.20(b)(1)(xviii),(g), and (h) require that: The assessment accurately reflects the residents status. A registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. An accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and	

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F 278	Continued From page 13 teeth. Resident #273 was noted to have her right prosthetic leg in place and was propelling herself independently in the room with the use of the prosthetic leg. NA #2 stated that Resident #273 did have some of her own teeth on the bottom and had an upper partial. She added that Resident #273 wore her prosthetic leg every day since she had been working with her and ambulated with it while working with the therapy department. An interview with the MDS Coordinator #2 on 05/24/17 at 11:41 AM revealed that she was unclear on what edentulous actually meant. She stated she did see Resident #273 prosthetic leg lying in the chair during the assessment period when she visited the resident but was not sure if she used it or not, and she had not talked with the staff to see if Resident #273 was using the prosthetic leg or not. An interview was conducted with the Director of Nursing (DON) on 05/24/17 at 12:10 PM. The DON stated she expected all MDS's to be completed as accurately as possible to reflect the current status of the resident. 4. Resident #272 was admitted to the facility on 05/09/17 with diagnoses that included atrial fibrillation, bradycardia, hypertension, hyperlipidemia, and others. Review of the most recent comprehensive minimum data set (MDS) dated 05/16/17 revealed that Resident #272 was cognitively impaired for daily decision making and extensive assistance with activities of daily living (ADL). The MDS indicated that Resident #272 was edentulous (having no teeth or tooth fragments).	F 278	should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. The information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) the interdisciplinary team completing the assessment. The Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. The observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. If it did not occur during the look back period, it is not coded on the MDS. The Director of Nursing or RN Designee will review OBRA assessments to ensure accurate coding for item set I5950, I5800, G0600D, L0200B and L0200Z Any issues will be reported to the Director of Nursing or Administrator for appropriate action. During the daily Clinical Meeting (Monday through Friday), the RN MDS Coordinator or Designee will review assessment	

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F 278	Continued From page 14 Review of the Dental Care Area Assessment (CAA) dated 05/17/17 read in part, Resident #272 had an upper partial and would proceed to care plan. An observation of Resident #272 was made on 05/22/17 at 3:05 PM revealed that Resident #272 had some natural teeth left. An interview with the MDS Coordinator #2 on 05/24/17 at 11:41 AM revealed that she was unclear on what edentulous actually meant and that was why she miscoded the MDS. She indicated she would correct the error immediately. An interview was conducted with the Director of Nursing (DON) on 05/24/17 at 12:10 PM. The DON stated she expected all MDS assessments to be completed as accurately as possible to reflect the current status of the resident.	F 278	reference dates for OBRA assessments. The Daily Clinical Meeting is attended by the Director of Nursing, Unit Managers, MDS Coordinators, Support Nurse, Therapy, HIM, Dietary Manager, Social Worker, The Administrator and others as needed. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Assessment Accuracy Tool. Five residents OBRA assessments will be reviewed weekly for 4 weeks, and then monthly for three months. The items reviewed on the QA Assessment Accuracy Tool will include: Section I-Active Diagnosis: Accuracy of Section I5950, I5800; Section G-Functional Status: Accuracy of Section G0600D; Section L-Oral/Dental Status: Accuracy of Section L0200B and L0200Z. Identified issues will be reported immediately to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, and the Administrator. Date of Compliance: June 16TH 2017	
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,	F 281		6/16/17

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F 281	Continued From page 15 as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to correctly transcribe wound care orders for a non-pressure related ulcer to the resident's right heel for 6 days for 1 of 1 sampled resident (Resident #266). The findings included: Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: methicillin resistant staphylococcus aureus (MRSA) septicemia, decubitus ulcer of sacral region stage 2 present on admission, diabetic ulcer of right great toe, pressure ulcer of thigh stage 3 present on admission, and diabetes mellitus. Review of the Wound Care Specialist Initial Evaluation dated 05/19/17 read in part, "wound of the left posterior ankle was healing and surgical excisional debridement of the site was performed." The recommended treatment was Santyl (medicated ointment) once daily. Review of physician order summary dated 05/01/17 through 05/23/17 revealed no physician order for a treatment to Resident #266's right heel wound. An observation of wound care was made on 05/22/17 at 4:06 PM with Nurse #2. Nurse #2 was observed to apply wound dressing that contained Santyl to Resident #266's right and left back of thigh/buttock area. Nurse #2 was observed to	F 281	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Corrective Action: Resident #266. Physician was notified on 5/24/2017. New physician orders placed and initiated as ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified, and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments	

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F 281	Continued From page 16 also apply a wound dressing that contained Santyl to Resident #266's right heel. Review of a physician order dated 05/24/17 read in part, "clean wound to right heel with wound cleaner and apply Santyl and cover with maxorb and dry dressing every other day." An interview was conducted with the Director of Nursing (DON) on 05/25/17 at 10:46 AM. The Assistant Director of Nursing (ADON) was present for the interview. The DON and ADON confirmed that the ADON was responsible for the management of wound care in the facility. The DON further explained that Resident #266 was seen by the wound care specialist on Friday 05/19/17 and they documented their notes off-site. The ADON then had to go into their system and see if the wound care notes were completed. The DON stated that the ADON had just received the report from 05/19/17 on 05/24/17 and had not had time to review them. She added that when the wound care specialist recommended the Santyl be used once daily, then a physician's order should have immediately been written and transcribed into Resident #266's medical record. They should not have waited until they got the report to initiate the prescribed treatment because sometimes it took several days for the facility to obtain a copy of the report. The ADON confirmed that he had not reviewed the wound specialist note and was not aware that the Santyl was ordered every day and not every other day and he would correct that immediately.	F 281	were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) and the interdisplinary care planning team on the fact that the services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not	

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F 281	Continued From page 17	F 281	receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 residents' charts with pressure or non-pressure wounds weekly to ensure that physician was notified, orders are followed and initiated as ordered. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017_____	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		6/16/17

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F 309	Continued From page 18 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to fully assess a	F 309	The statements made on this Plan of Correction are not an admission to and do	

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F 309	Continued From page 19 resident's skin to identify a non-pressure wound to the right heel on admission and failed to initiate treatment for 8 days for 1 of 1 sampled resident (Resident #266). The findings included: Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: methicillin resistant staphylococcus aureus (MRSA) septicemia, decubitus ulcer of sacral region stage 2 present on admission, diabetic ulcer of right great toe, pressure ulcer of thigh stage 3 present on admission, and diabetes mellitus. Review of Resident #266's discharge summary from the hospital dated 05/16/17 read in part, "decubitus ulcer of the sacrum stage 2/pressure ulcer of the thigh stage 3 present on admission. Wound care nurse to manage." The discharge summary did not indicate a right heel wound. Review of Initial Nursing Assessment dated 05/16/17 read in part, there was 5 small ulcers between left and right buttock. No other ulcers were identified on the initial nursing assessment. Review of a physician progress note dated 05/17/17 read in part, "Stage 3 decubitus to thigh and sacral decubitus. Wound doctor to see on Friday (05/19/17) and encourage resident to stay on side as much as possible." The report did not reference a right heel wound. Review of the Wound Care Specialist Initial Evaluation dated 05/19/17 read in part, "wound of the left posterior ankle was healing and surgical excisional debridement of the site was performed." The recommended treatment was	F 309	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Action: Resident #266. Physician was notified on 5/24/2017. New physician orders placed and initiated as ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified, and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes:	

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F 309	Continued From page 20 santyl once daily. Review of physician order summary dated 05/01/17 through 05/23/17 revealed no physician order for a treatment to Resident #266's right heel wound. An observation of wound care was made on 05/22/17 at 4:06 PM with Nurse #2. Nurse #2 was observed to apply a wound dressing that contained Santyl (medicated ointment) to Resident #266's right and left back of thigh/buttock area. Nurse #2 was observed to also apply a wound dressing that contained Santyl to Resident #266's right heel. Review of the medical record on 05/22/17 at 4:50 PM and again on 05/23/17 at 3:00 PM revealed no "Weekly Wound Review (non pressure)" assessment and no "Weekly Pressure Ulcer Review" assessment was present. Review of the daily nurse's notes in the medical record on 05/22/17 at 4:50 PM and again on 05/23/17 at 3:00 PM revealed no documentation of a right heel ulcer. An interview with Nurse #8 was conducted on 05/23/17 at 10:27 AM. Nurse #8 confirmed that she routinely cared for Resident #266 on first shift and the only wounds that Resident #266 had were "open spots on the back of thighs and in between her buttocks." During the interview Nurse #8 went and confirmed with the Assistant Director of Nursing (ADON) that those were the only ulcers that Resident #266 had. An interview with the ADON was conducted on 05/24/17 at 10:00 AM. The ADON confirmed that	F 309	Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident choices, including but not limited to the following: Pain Management and Dialysis. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility	

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F 309	Continued From page 21 he was responsible for the wound care management in the facility. The ADON stated that Resident #266 currently had a diabetic ulcer to her right great toe that was being treated with hydrogel every day. He added that Resident #266 currently had ulcers to the back of her thigh/buttock that were being treated with Santyl every other day. The ADON confirmed that Resident #266 had no other wounds or ulcers. He added that they recently placed Resident #266 on an air mattress. The ADON stated that on Friday 05/19/17 he and the medical doctor observed the above wounds and he initiated Santyl. He stated that he saw Resident #266 on 05/17/17 but did not document that in the medical record. An observation of wound care was made on 05/24/17 at 2:00 PM. The ADON removed old dressings from Resident #266 right great toe and heel and applied a new dressing to both areas that contained Santyl and a cover was then applied to both areas. The old dressing that was removed from the right heel contained a moderate amount of serosanguinous drainage. A follow up interview was conducted with the ADON on 05/24/17 at 2:22 PM. The ADON stated that Resident #266 did a have ulcer to the right heel on admission and the treatment for it was santyl. He added that it had been draining serosanguineous fluid since admission. The ADON indicated that he "just forgot about the wound to Resident #266's right heel." Review of a physician order dated 05/24/17 read in part, clean wound to right heel with wound cleaner and apply santyl and cover with maxorb and dry dressing every other day.	F 309	to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by reviewing 5 new admissions charts to ensure that skin check was completed and any pressure or non-pressure areas were identified and that the physician was notified, orders are followed and initiated as ordered. This will be done on weekly basis for 4 weeks then	

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F 309	Continued From page 22 An interview was conducted with Nurse #7 on 05/24/17 at 2:53 PM. Nurse #7 confirmed that she was the nurse that admitted Resident #266 on 05/16/17 and completed her initial skin assessment. Nurse #7 stated that Resident #266 had scattered bruises to both arms and 3 open areas on left buttock and 2 on the right buttock. Nurse #7 stated that Resident #266's right foot was wrapped with a dressing and she did not remove the dressing and does not know what kind of ulcer's were present under the dressing on admission. Nurse #7 stated the other foot was fine and had no ulcers. Nurse #7 was not aware of any ulcers on the right heel because she had not removed the dressing to visualize what was under it. An interview with the Director of Nursing was conducted on 05/25/17 at 10:00 AM. The DON stated that Nurse #7 should have removed the routine dressing from Resident #266's right foot to visualize what was under the dressing and documented it in the medical record. She added if there was a wound under the dressing then Nurse #7 should have initiated some type of wound care treatment in addition to notifying the ADON.	F 309	monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017_____	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 314		6/16/17

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F 314	Continued From page 23 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to initiate treatment orders on admission for a stage 3 pressure ulcer and once treatment orders were obtained, the facility failed to follow them. The resident was admitted to the facility with a stage 3 pressure ulcer and went 3 days before receiving treatment for 1 of 1 sampled resident (Resident #266). The findings included: Review of Resident #266's discharge summary from the hospital dated 05/16/17 read in part, decubitus ulcer of the sacrum stage 2/pressure ulcer of the thigh stage 3 present on admission. Wound care nurse to manage. Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: pressure ulcer stage 3, diabetes mellitus, hypertension, hyperlipidemia, and methicillin resistant staphylococcus aureus (MRSA) of unspecified site. Review of a physician progress note dated 05/17/17 read in part, stage 3 decubitus to thigh and sacral decubitus. Wound doctor to see on Friday (05/19/17) and encourage resident to stay	F 314	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F314 TREATMENT /SVCS TO PREVENT /HEAL PRESSURE SORES Corrective Action: Resident #266. Physician was notified on 5/24/2017. New physician orders placed and initiated as ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds	

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F 314	Continued From page 24 on side as much as possible. Review of the Wound Care Specialist's Initial Evaluation dated 05/19/17 read in part, Stage 3 pressure wound of the left buttock was pressure ulcer in etiology and the recommended treatment was Santyl (medicated ointment) once daily. Review of physician order dated 05/19/17 read, santyl to buttocks/sacral area every other day after cleaning with wound cleaner for wound care. Review of the Medication Administration Record (MAR) dated 05/01/17 through 05/31/17 read in part, santyl ointment to buttocks/thigh topically every other day for wound care. This was initialed on 05/19/17, 05/21/17, and 05/23/17 indicating that the treatment had been completed on those days. The most recent comprehensive minimum data set (MDS) dated 05/23/17 remained in progress. An observation of Nurse #2 was made on 05/22/17 at 4:06 PM performing wound care on Resident #266. Nurse #2 was observed to apply a wound dressing that contained Santyl to Resident #266's left buttock/thigh area and then applied a cover to hold the santyl dressing in place. Nurse #2 did not clean the wound with wound cleaner per the physician order. An interview with Nurse #2 was conducted on 05/22/17 at 4:28 PM. Nurse #2 stated she was helping the wound nurse out but generally she worked the weekends on a medication cart. She stated she did not have what she needed to clean the wound. She added if "I would have brought a bottle of wound cleaner into Resident #266's	F 314	were identified, physician was notified, and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that when it comes to Skin integrity, specifically Pressure ulcers. Based on the comprehensive assessment of a resident , the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing . All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at	

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F 314	Continued From page 25 room it would have had to stay in here because she was on isolation precautions." Nurse #2 stated that she should have turned the call light on and asked someone to bring her some wound cleaner and she should have properly cleaned the wound before applying the dressing. An interview with the Assistant Director of Nursing (ADON) was conducted on 05/24/17 at 10:00 AM. The ADON confirmed that he was in charge of managing wounds in the facility. He stated that when Resident #266 was admitted to the facility the staff should have implemented some type of treatment orders and he would have followed up the next day to make sure the treatment was appropriate. The ADON stated that no wound orders were transcribed from the hospital and they should have been. He added that he expected all nurses that performed wound care to follow the physician order and clean the wound with wound cleaner. The ADON added that he would clarify with the wound specialist that he wanted the Santyl once a day per his note and then take care of transcribing those orders that were originally given on 05/19/17. An interview with Nurse #7 was conducted on 05/24/17 at 2:53 PM. Nurse #7 confirmed that she had admitted Resident #266 to the facility and did complete the skin assessment. Nurse #7 stated that when Resident #266 admitted from the hospital she had no wound care orders and "I did not initiate any." She added that she did put in a referral to the wound nurse to assess her in the morning. Nurse #7 stated that if she discovered a pressure ulcer she generally would put an order for the wound nurse to assess and then cover the pressure ulcer with dry dressing.	F 314	each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by observing 5 residents' wound care treatments to ensure that physician orders are followed and treatments are applied appropriately. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Director of Nursing, Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator	

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F 314	Continued From page 26 An interview with the Director of Nursing (DON) was conducted on 05/25/17 at 10:46 AM. The DON stated that she expected Nurse #7 to initiate some kind of wound care for Resident #266's wound on admission in addition to notifying the wound nurse that he needed to follow up. The DON stated that when the wound specialist saw Resident #266 and recommended treatment of Santyl once daily that order should have been transcribed and completed daily as ordered. She added that they will have to make sure everyone is clear of what the wound specialist wanted and she would try arrange for the doctor to write the order while in the facility instead of waiting to obtain the report. She also stated she expected all nurses that were completing wound care to follow the physician order and clean the wound with wound cleaner.	F 314	for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: _June 16th, 2017_____	
F 323 SS=G	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		6/16/17

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F 323	Continued From page 27 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 staff interviews and record review the facility failed to implement effective interventions to protect a resident from injury, the resident fell 7 times in 11 days. One fall resulted in an Emergency Department visit to repair a facial laceration for 1 of 1 sampled residents (Resident #75). The findings included: Resident #75 was admitted to the facility on 04/21/17 with diagnoses that included laceration of the scalp, history of falls, Alzheimer's disease, a urinary tract infection and others. The admission Minimum Data Set (MDS) dated 04/28/17 specified the resident's cognition was intact, he required limited one person assistance with activities of daily living. The MDS also specified the resident was not steady with balance during transitions and walking and needed stabilization with staff assistance; the resident had a history of falls but no falls since admission. The MDS also specified the resident was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #75 was discharged to a Memory Care Unit before Care Area Assessments could be	F 323	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Corrective Action: Resident #75 Discharged on 5/10/2017 to a Memory care unit. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 6/15/2017 a falls review meeting was held in the Weekly Quality of Life meeting. Risk assessments were completed on all current residents by 6/14/2017. In this meeting all residents were reviewed for high falls risk and current interventions in place to prevent falls and the need for	

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F 323	Continued From page 28 completed. A care plan dated 05/08/17 for the resident's risk for falls specified interventions that included: - Remind resident to use call light with transfers - Staff to ensure nonskid socks were in place when out of bed - Anticipate needs as much as possible - Activities to minimize potential for falls while providing diversion and distraction - Staff to make more frequent care rounds to offer toileting - Remind resident to use call light with assistance to the bathroom - Ensure personal items were in reach before leaving the room - Continue current interventions The facility provided incident reports for Resident #75 which identified he had fallen 7 times in 11 days. On 05/25/17 at 9:35 AM the Unit Manager was interviewed and described Resident #75 to be very confused, restless, agitated, impulsive and needed constant reminding to sit down; and stated the resident did not know what he was doing because of dementia. The Unit Manager explained that she, the Administrative nurses and Administrator reviewed falls each day Monday through Friday to determine root cause analysis for each fall and implement interventions to prevent injuries from falls and fall reoccurrences. The Unit Manager reviewed Resident #75's 7 falls while in the facility and the interventions implemented after the fall occurred. The Unit	F 323	additional interventions for residents with poor safety awareness. This was completed on 6/15/2017. In addition to this, any new interventions put in place were added to the individual residents care plan by the MDS Coordinator and were reflected on the Kardex and Care plan respectively. Systemic Changes: Director of Nursing and /or Designee in serviced all staff (full time, part time, and PRN) to inform that the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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. Assess the resident for risk of entrapment from bed rails prior to installation, Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation, Ensure that the bed's dimensions are appropriate for the residents size and weight. When a resident has a fall, the person discovering the resident reassures the resident and immediately alerts the primary nurse. The nurse assesses the resident for injuries. With suspected fractures of limbs, the limbs in question are immobilized and an order to send to the ER is obtained. When other fractures	

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F 323	Continued From page 29 Manager used the incident reports and care plan to review the following falls: a. On 04/29/17 at 12:15 PM the resident stood up from his wheelchair and fell in the floor without injury. The interventions implemented was to remind the resident to call for assistance. The Unit Manager stated that due to the resident cognition this intervention was not effective but the facility wanted to try it because the facility preferred to use least restrictive measures. Review of the medical record revealed a nurse's entry made by Nurse #2 that stated the resident fell in his room trying to get up out of his wheelchair without assistance. Nurse #2 was unable to be interviewed. b. On 05/01/17 9:53 AM the resident was found in the floor in the bathroom without injury. The Unit Manager stated the facility implemented non-skid socks when out of bed after this fall. A nurse's entry dated 05/01/17 made by Nurse #1 specified the resident was found in the bathroom floor and had attempted to ambulate unassisted. On 05/25/17 at 8:28 AM Nurse #1 was interviewed and explained Resident #75 was confused and did not ask for assistance because he tried to do things for himself such as walking to the bathroom. She explained that the resident	F 323	are suspected of limbs, the limbs in questions are immobilized and an order to send to the ER is obtained. When other fractures are suspected the resident is kept immobilized on the floor and on order to send to the ER is obtained. Vital signs are obtained. The attending physician is notified immediately of the fall if injury is apparent. If no injury is apparent the physician is notified. Notify the family or resident representative. Initial documentation in the nurse's notes needs to be completed and through. The resident is to be thoroughly assessed every shift after the incident with complete vital signs for 72 hours. A neuro assessment is done every shift for 72 hours or according to MD orders. A Quality assurance incident report is to be completed in detail and all spaces completed. The Director of nursing or designee should make sure that the resident has been thoroughly assessed, the physician and the family have been notified, and the incident report has been fully completed. Then the incident report should be investigated and a root cause analysis identified. All residents who have fallen should be referred to the Quality Assurance Committee. Interventions should be documented on the residents care plan. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into	

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F 323	Continued From page 30 thought that if he could be independent then his family would take him home. The nurse added that Resident #75's cognition was such that you could tell him to call for assistance but 5 minutes later he had forgotten. c. On 05/02/17 at 1:03 PM the resident was found sitting in the floor beside the bathroom without injury. The Unit Manager stated the facility reminded the resident to use call light to ask for assistance to the bathroom and that this was the same intervention as on 04/29/17. No nurse's entry was made in the medical record related to this fall on 05/02/17. The nurse assigned to the resident was Nurse #3. Attempts were made to contact Nurse #3. d. On 05/05/17 at 7:50 PM the resident was found in the floor lying on his back and the floor was wet from a water pitcher that was knocked over by the resident. The resident had a skin tear to his right elbow. The Unit Manager reported that the intervention implemented was to remind staff to keep personal items in reach. A nurse's entry dated 05/05/17 made by Nurse #4 read in part, the resident was found lying on his back and had apparently knocked over his water pitcher. The resident reported that she had slipped on the water. Nurse #4 was unable to be interviewed.	F 323	the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by completing a daily falls review during daily clinical Quality of life meeting to ensure a complete investigation of the fall, root cause, and interventions are initiated. Weekend falls will be reviewed on Monday by the clinical team. The review will ensure that the physician was notified of the fall promptly, physician orders were initiated, resident representative was notified and plan of care was updated. A falls review meeting will be held during the weekly Quality of Life meeting to review weekly falls to ensure that interventions are sustained. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary	

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F 323	Continued From page 31 e. On 05/08/17 at 11:00 PM the resident was found under the sink in his bathroom bleeding from his head. Orders were obtained and the resident was sent to the Emergency Department and returned to the facility with sutures to his head. The Emergency Department report dated 05/08/17 specified the resident presented with a facial laceration that required sutures. The Unit Manager reported that staff were educated to provide more frequent rounds on the resident. She stated that this information was provided orally to nurse aides assigned to the resident. A nurse's entry made by Nurse #1 dated 05/09/17 at 1:10 AM read in part that on 05/08/17 at 11 PM the resident was found in the floor of the bathroom bleeding after he tried to ambulate to the bathroom. On 05/25/17 at 8:28 AM Nurse #1 was interviewed and explained Resident #75 was confused and did not ask for assistance because he tried to do things for himself such as walking to the bathroom. Nurse #1 reported that she was assigned to the Resident on 05/08/17 on the 3 PM to 11 PM shift when the resident was found in the bathroom floor bleeding. She stated an order was received to send the resident to the Emergency Department. The nurse stated she had suggested using a personal alarm for the resident but was told the facility did not use personal alarms on residents. The nurse added that Resident #75's cognition was such that you could tell him to call for assistance but 5 minutes later he had forgotten. Nurse #1 reported that the	F 323	Manager, Wound Nurse. Date of Compliance: June 16th 2017	

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facility had adequate staffing to monitor the resident but he almost required a sitter. The nurse was unaware of interventions in place to keep the resident from falling other than constant reminding not to get up unassisted. The nurse reported that interventions for the resident had not changed because the resident was ambulatory and confused and needed constant redirection and monitoring.

On 05/25/17 at 11:11 AM nurse aide (NA) #1 was interviewed on the telephone and stated she worked as needed but was assigned to Resident #75 on 05/08/17 from 3 PM to 11 PM. She explained this was the 2nd or 3rd time she had cared for the resident and that she was aware the resident needed assistance to the bathroom and had fallen but was not aware she was to provide more frequent monitoring. The NA reported that on 05/08/17 the resident appeared to be his usual self. The NA stated that she was on lunch break when the resident fell but estimated that she checked on the resident "about 30 minutes" prior to the fall.

f. On 05/09/17 the resident was found in the floor in his room without injury. The Unit Manager stated no new interventions were developed to keep the resident from falling.

No nurse's entry was made in the medical record related to this fall on 05/02/17. The nurse assigned to the resident was Nurse #3. Attempts were made to contact Nurse #3.

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F 323	Continued From page 33	F 323		

g. On 05/09/17 the resident was in the floor beside his bed without injury. The Unit Manager stated no new interventions were developed to keep the resident from falling.

A nurse's entry made by Nurse #5 on 05/09/17 read in part the resident was found in the floor and did not appear injured.

Nurse #5 was unable to be interviewed.

Resident #75 was discharged on 05/10/17.

In the same interview, after reviewing Resident #75's falls, the Unit Manager reported the interventions had not been effective.

On 05/25/17 at 10:02 AM the MDS Coordinator was interviewed and explained that all residents admitted to the facility at risk for falls received an interim care plan with basic interventions that included: anticipate needs, wear non-skid socks, keep personal items in each and remind to call for assistance. She added that once a resident started falling in the facility, she and the Administrative nursing team would "start to drill down and individualize the care plan."

On 05/25/17 at 2:08 PM the Director of Nursing (DON) was interviewed and stated that facility had made changes to Resident #75's care plan to address falls. The DON explained the facility tried to utilize the least restrictive safety

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F 323	Continued From page 34 measures.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep two of two nourishment room microwaves clean for use. The findings included:	F 371	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction	6/16/17

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F 371	Continued From page 35 On 05/22/17 at 9:57 AM an initial tour of the kitchen was made with the Dietary Manager (DM). During the observations, the two nourishment rooms were also observed. On 05/22/17 at 10:08 AM nourishment room 2's microwave was inspected. The inside of the microwave contained burnt food debris splattered along the interior walls and ceiling of the microwave. The DM was interviewed and stated the microwave needed to be cleaned and she was not aware how often it was cleaned. On 05/22/17 at 10:10 AM observations were made of nourishment room 1's microwave. The microwave was noted to have burnt food debris splattered inside. The DM was interviewed and stated the microwave needed to be cleaned and she was not aware how often it was cleaned.	F 371	constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY Corrective Action for Resident Affected: No specific resident is identified. Corrective Action for Resident Potentially Affected: All residents residing in the facility have potential to be affected. The facility is to ensure that dietary staff maintain nourishment room microwaves, all food preparation and service equipment clean and properly stored. Systemic Changes: The Environmental Services Director in serviced all Housekeeping staff on 5/26/17 regarding proper cleaning of microwaves in the nourishment units to ensure that microwave ovens are inspected during the day and cleaned as required. An audit tool was developed to monitor the inspection of the microwave ovens. Any housekeeping employee who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Housekeeping employees. A comprehensive audit tool was put into place to monitor compliance 6/1/17. Monitoring: To ensure compliance, the Environmental Services Director or designee will monitor this issue using the QA survey tool. This	

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F 371	Continued From page 36	F 371	will be done 5 days per week, including weekend days, for 4 weeks then weekly for 2 additional months or until resolved by QOL/QA committee. Reports will be presented to the weekly QOL/QA Committee by the Director of Environmental Services or designee and Corrective Action initiated as appropriate. Any immediate concerns will be brought to the Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Social Services. Date of Compliance: __June 16th, 2017_____	
F 431 SS=D	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. (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	F 431		6/16/17

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F 431	Continued From page 37 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 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 lock 2 of 4	F 431	The statements made on this Plan of Correction are not an admission to and do	

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F 431	Continued From page 38 medication carts, (100 hall medication cart and 400 hall medication cart) which were left unattended. The findings included: 1. On 05/23/17 at 3:24 PM the 400 Hall medication cart was parked at the nurses' station. The nurses' station was vacant of staff but 5 residents were seated in wheelchairs at the nurses' station. The 400 Hall medication cart was unlocked and unattended. On 05/23/17 at 3:30 PM the Assistant Director of Nursing (ADON) entered the building from the smoking area, walked by the medication cart and observed that it was unlocked. The ADON was interviewed and stated the cart should be locked when unattended and attempted to locate the nurse assigned to the medication cart. The ADON was able to locate the medication aide assigned to the cart, she was on break. On 05/23/17 at 3:33 PM Medication Aide #1 was interviewed and stated she didn't realize she left the cart unlocked and was trained to lock medication cart before leaving the cart unattended. 2. An observation of the 400 hall medication cart was made on 05/23/17 at 4:16 PM. The medication aide was standing at the medication cart and could not find a medication she needed. The medication aide was observed to walk away from the medication cart down an adjacent hallway to get the nurse. The medication aide left	F 431	not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS Corrective Action: 100 and 400 hall Medication carts where locked and secured while the nurse was not in attendance. Medications were immediately secured properly. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done by DON on 6/14/17 and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed, open insulin by the nurse. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that the facility must store all drugs and biologicals in	

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F 431	Continued From page 39 the medication cart unlocked and there was 3 residents in wheelchairs parked directly in front of and just beside the medication cart. The medication aide was away from her medication cart for approximately 2 minutes. An interview was conducted with Medication Aide #1 on 05/23/17 4:18 PM. Medication Aide #1 stated that this was her second day working at the facility and she was nervous. Medication Aide #1 stated that her cart was supposed to always be locked when she was not near it. An interview with the Director of Nursing (DON) was conducted on 05/25/17 at 11:41 AM. The DON stated that medication carts are to be locked at all times when not in use. She added that the use of Medication Aides on the medication carts was new to the facility and stated that "Medication Aide #1 would no longer be working on the medication cart in the facility." The DON stated the staff needed to understand the importance of making sure the medication carts are locked when left unattended. 3. An observation of the 100 hall medication cart was made on 05/23/217 at 3:29 PM. The medication cart was parked outside of a resident room and was noted to be unlocked and the keys to the medication cart were noted to be lying on top of the medication cart. The door to the resident room was closed and no staff was attending the medication cart. The medication cart was left unattended for 5 minutes before the nurse exited the room and grabbed the keys to the medication cart and locked the cart. An interview with Nurse #6 was conducted on	F 431	locked compartments under proper temperature controls, and permit only authorized personnel to have access to the key's. The facility must also separately lock, and have permanently affixed compartments for storage of controlled drugs. 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. This in service was completed by 6/14/2017. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. Facility will monitor compliance by auditing each medication cart, and treatment cart and any other areas that medication is stored to ensure that they are secured properly at all times. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate	

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F 431	Continued From page 40 05/23/17 at 3:36 PM. Nurse #6 stated she knew that the medication cart was to be locked and she should always have her keys with her and stated, "I just went in and knew that I would be right back out." An interview with the Director of Nursing (DON) was conducted on 05/25/17 at 11:41 AM. The DON stated that medication carts were to be locked at all times when not in use and the keys to the medication cart should never be left on top of the medication cart. She added the keys should be with the nurse that was responsible for the cart.	F 431	concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017	
F 441 SS=D	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: (i) A system of surveillance designed to identify	F 441		6/16/17

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(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 441	Continued From page 41	F 441		

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 spread of infection.

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F 441	Continued From page 42 (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 staff failed to wash hands after performing finger stick glucose test and after performing incontinent care for 2 of 3 residents (#255 and #266). The findings included: Review of a facility policy titled "Clostridium Difficille (C-Diff)" dated July 2002 and revised March 2004 read in part, gloves must be worn with resident care and environment contact. Hand washing with soap and water has demonstrated to be very important to prevent the spread of C-Diff on the hands of healthcare workers. Hand washing is with soap and water as alcohol gel is not effective against C-Diff. Review of facility policy titled "Infection Control Guidelines" dated July 2002 and revised January 2010 read in part, all health care workers shall routinely use appropriate barrier precautions to prevent contact with and/or spread of infection. Gloves should be changed after contact with a patient and hands washed. 1. Resident #255 was admitted to the facility on 05/05/17 with diagnoses that included diabetes mellitus. Review of the most recent minimum data set (MDS) dated 05/12/17 revealed that Resident #255 was cognitively intact and required extensive assistance with activities of daily living	F 441	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Corrective Action: Resident # 255 Medication was administered as ordered maintaining standard precautions during medication administration. Resident #266 Hand washing was performed after Incontinence care was provided, maintaining standard precautions. Wound care treatment was provided as ordered maintaining standard precautions. Facility immediately in serviced all Nursing staff (RN, LPN, CNAs and Med Techs: Full time, Part Time and PRN) about infection control, preventing spread of infection during medication administration and wound care treatment. To ALWAYS maintain standard precautions during medication administration, wound care treatment, and to always wash their hands	

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F 441	Continued From page 43 (ADL). Review of a physician order for Resident #255 dated 05/22/17 read, contact isolation for C-Diff. An observation of Nurse #6 was made on 05/23/17 at 3:40 PM. Nurse #6 was observed to enter Resident #255's room that had a sign on the door that stated "Contact Isolation Precautions." Nurse #6 was observed to don gown and gloves prior to entering room. Once in the room Nurse #6 proceeded to perform a finger stick glucose check on Resident #255. After obtaining the finger stick glucose test Nurse #6 removed her gown and gloves and exit Resident #255's room, she returned to the medication cart and used hand sanitizer gel on her hands and then entered another residents rooms to administer medications. An interview was conducted with Nurse #6 on 05/23/17 at 3:55 PM. Nurse #6 stated she was fairly new to the facility and she did not recall any guidelines that were provided to her on hand washing. She recalled going through the orientation process but could not recall any specific instructions on hand washing or the use of hand sanitizer gel. Nurse #6 stated she always used hand sanitizer gel between patient's even patients on contact isolations precautions for C-Diff. An interview with the Assistant Director of Nursing (ADON) was conducted on 05/24/17 at 10:15 AM. The ADON confirmed that he was also responsible for the infection control program in the facility. The ADON confirmed that Nurse #6 had recently gone through orientation and the training on infection control. He stated that the	F 441	when resident contact is made after performing incontinence care. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Director of Nursing observed Medication Administration Passes on Nurses (RN, LPN and Med Techs). All residents medications administered as ordered maintaining standard precautions and/ contact isolation during medication administration. Director of Nursing observed hand washing during treatment and medication administration, and after incontinence care. All nursing staff observed washed hands after performing incontinence care during medication and treatment administration. Systemic Changes: Director of Nursing and/or Designee in serviced all Nursing staff (RN, LPN, CNAs and Med Techs: full time, part time, and PRN) about infection control, preventing spread of infection during medication administration and during and after performing incontinence care. The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;(2) Decides what procedures, such as isolation, should be applied to an individual resident; and(3)	

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F 441	Continued From page 44 employees were required to watch a power point presentation on infection control that included blood borne pathogens, use of personal protective equipment (PPE), and hand washing. The ADON stated that the facility policy did not specify the use of hand sanitizer gel versus hand washing so it was "ok to use hand sanitizer even after providing care to residents on contact isolation for C-Diff", he added "they can use hand sanitizer anytime unless their hands are visibly soiled." An interview was conducted with the Director of Nursing (DON) on 05/25/17 at 9:50 AM. The DON stated that "I drill the staff about infection control and the one time you cannot use hand sanitizer is with C-Diff." The DON stated that Nurse #6 was fairly new to the facility and had been through an extended orientation program and she expected Nurse #6 to wash her hands with soap and water after performing the finger stick glucose test on Resident #255 and before providing care to another resident. 2. Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included methicillin resistant staphylococcus aureus (MRSA) of unspecified site and others. The comprehensive minimum data set (MDS) dated 05/23/17 remained in progress. Review of a physician order dated 05/16/17 read, maintain contact precautions due to MRSA of foot. An observation of Nurse #2 was made on 05/22/17 at 4:06 PM. Nurse #2 was observed to don gown and gloves and enter Resident #266's	F 441	Maintains a record of incidents and corrective actions related to infections.(b) Preventing Spread of Infection(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.(2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Medications are administered at the time they are prepared. Medications are not pre-poured. The person who prepares the dose for administration is the person who administers the dose. Hand hygiene should be performed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. All staff was in-serviced about contact precautions and use of PPD. Always observe Standard Precaution and/or contact isolation during any medication administration. Wash hands if resident contact is made. Wash hands before and after resident contact. Wash hands when soiled. Standard Precautions should be used with all procedures involving blood or other potentially infectious body fluids.	

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F 441	Continued From page 45 room. After entering the room Resident #266 requested to use the bedside commode. Nurse #2 assisted Resident #266 from the bed to the bedside commode. When Resident #266 was finished Nurse #2 was observed to provide incontinent care and assisted Resident #266 with putting on clean pull up and then pulling up her pull up and pants. Nurse #2 then proceed to perform wound care to Resident #266's right foot wound. Nurse #2 removed the soiled dressing and placed a new dressing and did not change her gloves after the incontinent care and subsequent wound care. An interview was conducted with Nurse #2 on 05/22/17 at 4:28 PM. Nurse #2 explained that she was the weekend supervisor and she was helping out the wound nurse today. Nurse #2 stated she had changed her gloves after providing incontinent care but she did not wash her hands. She added that Resident #266 was on contact isolation and it was fine to not wash hands between wound and incontinent care as long as I changed my gloves and my hands are not visible soiled. An interview was conducted with Director of Nursing (DON) on 05/25/17 at 10:05 AM. The assistant Director of Nursing (ADON) was present during this interview. The DON stated that she expected anytime a staff member changed their gloves that they wash their hands with soap and water. The DON stated that she expected Nurse #2 to change her gloves and wash her hand with soap and water after providing incontinent care and before performing wound care to Resident #266.	F 441	Ointments and drops should be kept in separate containers labeled with the resident's name. Liquid and PO medications should be stored separately in the medication carts. No medications used for treatments such as creams should be kept in the medication cart. These items should be kept in the treatment cart. Any medication used for the treatment of a resident who is on isolation precautions should be stored separately from other resident's treatment supplies and should be locked to prevent unauthorized access. Medication carts shall be cleaned when visibly soiled. Food and utensils shall be handled in a sanitary manner. Unused medication cups shall be kept covered or inverted. Sharps containers on medication carts shall be affixed or secured to prevent spillage. When administering oral medications, never touch pills or tablets with bare hands. If blister pack medications are prepared by pharmacy, punch the medication directly into a medication cup for dispensing. If tablets are in a bottle, then pour the medication into the lid and then transfer ordered dose into the medication cup. Clean any spilled liquid medication immediately. When administering eye drops, Always wear gloves. Wash hands after administration. Ensure that eye medication dispensers/containers do not touch the resident's eyes. If eye secretions are present, cleanse the lid with saline. Always wipe from the inner canthus outward. Always use separate tissue wipes or cotton balls for each eye	

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F 441	Continued From page 46	F 441	to prevent cross contamination. When administering injections, Always wear gloves. Wash hands after administration. Use sterile technique when preparing the medication for injection. Cleanse the site with an antiseptic prior to administration of the injection. Dispose of the sharp in an appropriate container immediately following administration. Monitor the injection site for sign and symptoms of infection. When administering medications via syringe, the syringe should be used for one resident only. Syringe shall be changed at least every 24 hours. Syringe shall be rinsed thoroughly, separated and dried thoroughly after each use and placed in cover by bedside or in a plastic bag, which is attached to feeding pole ready for next use. Wash hands before and after resident contact. Wash hands when soiled. Wash hands after performing incontinence care. This in services were completed on June 14th 2017 Any nursing staff member (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of nursing or designee will monitor this issue using	

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F 441	Continued From page 47	F 441	the QA survey tool. Facility will monitor compliance by observing 5 different medication or treatment administration passes done by an RN or LPN or Med aides during any shift. This will be done to ensure that standard precautions and/or contact isolation are maintained during medication administration and that hands are washed if resident contact is made. The facility will also monitor compliance by observing handwashing for 5 nursing staff after performing incontinence care. This will be done on a weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017	
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 490		6/16/17

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F 490	Continued From page 48 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have continued non-compliance with F-431, drug storage. The findings included: Cross refer to F-431: Based on observations and staff interviews the facility failed to lock 2 of 4 medication carts (100 and 400 halls) when left unattended. The facility was cited for F-431 in May 2016 for failing to label open insulin and failing to lock a medication cart when left unattended. The facility was recited for F-431 in June 2016 for leaving medications unattended at the nurses' station and failed to secure a medication cart when left unattended. On 05/25/17 at 3:42 PM the Administrator was interviewed and explained the facility had developed in-services and monitoring specific to drug storage due to past citations. She added that after months of monitoring she believed the facility was in compliance with the regulation and had ended the monthly monitoring and reporting of drug storage to the Quality Assurance	F 490	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F490 EFFECTIVE ADMINISTRATION /RESIDENT WELL-BEING Corrective Action: Cross reference Tag F490 to Tag F431 No residents identified. 100 and 400 hall Medication carts where locked and secured while the nurse was not in attendance. Medications were immediately secured properly. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Cross Reference Tag F490 to Tag F431 All residents have the potential to be affected by the alleged practice. Audits were done by DON on 6/14/17 and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also	

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F 490	Continued From page 49 Committee.	F 490	any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed, open insulin by the nurse. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, full time, part time, and PRN) that : Cross reference Tag F490 to Tag F431 No residents identified. The Cooperate Nurse Consultant in-serviced the Nursing Home Administrator on 6/12/2017 that A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing will monitor this issue using the QA survey tool. Facility will monitor compliance of QA for F 431. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee.	

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F 490	Continued From page 50	F 490	Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		6/16/17

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F 514	Continued From page 51 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to document two falls in the medical record for 1 of 1 sampled resident that had fallen (Resident #75) and failed to document a wound for 1 of 1 resident with a wound (Resident #266). The findings included: 1. Resident #75 was admitted to the facility on 04/21/17 with diagnoses that included laceration of the scalp, history of falls, Alzheimer's disease, a urinary tract infection and others. The admission Minimum Data Set dated 04/28/17 specified the resident's cognition was intact, he required limited one person assistance with activities of daily living. The facility provided incident reports for Resident #75 which identified he had fallen 7 times in 11 days. The falls occurred on:	F 514	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F514 RES RECORDS-COMPLETE/ACCURATE /ACCESSIBLE Corrective Action: Resident #75 Discharged on 5/10/2017 to a Memory care unit. Resident #266. Physician was notified on 5/24/17. New physician orders placed and initiated as ordered. Care plan updated. Resident and Resident's representative notified on 5/24/17.	

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F 514	Continued From page 52 - 04/29/17 - 05/01/17 - 05/02/17 - 05/05/17 - 05/08/17 - 05/09/17 - 05/09/17 Review of the medical record revealed that no documentation was made by the nurse related to the falls on 05/02/17 or 05/09/17. Nurse #3 was the nurse for Resident #75 on the two dates. Attempts were made to contact Nurse #3 for an interview. On 05/25/17 at 10:33 AM the Administrator reviewed the medical record and reported there was no documentation that the resident fell on 05/02/17 and 05/09/17. The Administrator explained that it appeared when Nurse #3 completed the incident reports for the falls she failed to link the documentation to the electronic medical record. The Administrator stated the incident reports were not part of the medical record and nurses should document any incident in the medical record. 2. Resident #266 was admitted to the facility on 05/16/17 with diagnoses that included: methicillin resistant staphylococcus aureus (MRSA) septicemia, decubitus ulcer of sacral region stage 2 present on admission, diabetic ulcer of right great toe, pressure ulcer of thigh stage 3 present on admission, and diabetes mellitus. Review of Resident #266's discharge summary	F 514	Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. On 6/15/2017 a falls review meeting was held in the Weekly Quality of Life meeting. Risk assessments were completed on all current residents by 6/14/2017. In this meeting all residents were reviewed for high falls risk, incident documentation and current interventions in place to prevent falls and the need for additional interventions for residents with poor safety awareness. This was completed on 6/15/2017. In addition to this, any new interventions put in place were added to the individual residents care plan by the MDS Coordinator and were reflected on the Kardex and Care plan respectively. All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified, and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Systemic Changes: Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time,	

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F 514	Continued From page 53 from the hospital dated 05/16/17 read in part, "decubitus ulcer of the sacrum stage 2/pressure ulcer of the thigh stage 3 present on admission. Wound care nurse to manage." The discharge summary did not indicate a right heel wound. Review of Initial Nursing Assessment dated 05/16/17 read in part, there were 5 small ulcers between left and right buttock. No other ulcers were identified on the initial nursing assessment. Review of a physician progress note dated 05/17/17 read in part, "Stage 3 decubitus to thigh and sacral decubitus. Wound doctor to see on Friday (05/19/17) and encourage resident to stay on side as much as possible." The report did not reference a right heel wound. Review of physician order summary dated 05/01/17 through 05/23/17 revealed no physician order for a treatment to Resident #266's right heel wound. An observation of wound care was made on 05/22/17 at 4:06 PM with Nurse #2. Nurse #2 was observed to apply a wound dressing that contained Santyl (medicated ointment) to Resident #266's right and left back of thigh/buttock area. Nurse #2 was observed to also apply a wound dressing that contained Santyl to Resident #266's right heel. Review of the medical record on 05/22/17 at 4:50 PM and again on 05/23/17 at 3:00 PM revealed no "Weekly Wound Review (non pressure)" assessment and no "Weekly Pressure Ulcer Review" assessment was present. Review of the daily nurse's notes in the medical	F 514	part time, and PRN) on the fact that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility must develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, Establish policies and procedures to investigate any such allegations including training. All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further instructions. Director of Nursing and /or Designee in serviced all staff (full time, part time, and PRN) to inform that the facility must ensure that the resident environment	

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F 514	Continued From page 54 record on 05/22/17 at 4:50 PM and again on 05/23/17 at 3:00 PM revealed no documentation of a right heel ulcer. An interview with the ADON was conducted on 05/24/17 at 10:00 AM. The ADON confirmed that he was responsible for the wound care management in the facility. He added that they recently placed Resident #266 on an air mattress. The ADON stated that on Friday 05/17/17 he and the medical doctor observed the Resident #266's wounds and he initiated Santyl. The ADON stated that he saw Resident #266 on 05/17/17 but did not document that in the medical record. A follow up interview was conducted with the ADON on 05/24/17 at 2:22 PM. The ADON stated that Resident #266 did a have ulcer to the right heel on admission and the treatment for it was santyl. He added that it had been draining Serosanguineous fluid since admission. The ADON indicated that he "just forgot about the wound to Resident #266's right heel." An interview was conducted with the Director of Nursing (DON) on 05/25/17 at 10:46 AM. The DON stated that she expected the medical record to be complete and accurate at all times to reflect the resident's skin status.	F 514	remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 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. Assess the resident for risk of entrapment from bed rails prior to installation, Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation, Ensure that the bed's dimensions are appropriate for the residents size and weight. When a resident has a fall, the person discovering the resident reassures the resident and immediately alerts the primary nurse. The nurse assesses the resident for injuries. With suspected fractures of limbs, the limbs in question are immobilized and an order to send to the ER is obtained. When other fractures are suspected of limbs, the limbs in questions are immobilized and an order to send to the ER is obtained. When other fractures are suspected the resident is kept immobilized on the floor and on order to send to the ER is obtained. Vital signs are obtained. The attending physician is notified immediately of the fall if injury is apparent. If no injury is apparent the physician is notified. Notify the family or resident representative. Initial documentation in the nurse's notes needs to be completed and through. The	

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F 514	Continued From page 55	F 514	resident is to be thoroughly assessed every shift after the incident with complete vital signs for 72 hours. A neuro assessment is done every shift for 72 hours or according to MD orders. A Quality assurance incident report is to be completed in detail and all spaces completed. The Director of nursing or designee should make sure that the resident has been thoroughly assessed, the physician and the family have been notified, and the incident report has been fully completed. Then the incident report should be investigated and a root cause analysis identified. All residents who have fallen should be referred to the Quality Assurance Committee. Interventions should be documented on the residents care plan. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Director of Nursing or designee will monitor this issue using the QA survey tool. The facility will monitor compliance by observing 5 residents' wound care treatments to ensure that physician orders are followed and treatments are applied appropriately. Facility will monitor compliance by	

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F 514	Continued From page 56	F 514	completing a daily falls review (including weekends) during daily clinical Quality of life meeting to ensure a complete investigation of the fall, root cause, and interventions are initiated. The review will ensure that the physician was notified of the fall promptly, physician orders were initiated, resident representative was notified and plan of care was updated. A falls review meeting will be held during the weekly Quality of Life meeting to review weekly falls to ensure that interventions are sustained. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		6/16/17

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F 520	Continued From page 57 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the	F 520	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	

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F 520	Continued From page 58 committee put into place in May 2016 and June 2016. This was for 4 recited deficiencies originally cited in May 2016 on an annual recertification survey and in June 2016 on a follow-up survey. The deficiencies were in the areas of provide services to treat pressure ulcers, maintain kitchen sanitation, drug storage and infection control. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: This tag is cross referred to: 1a. F-314 Based on observation, record reviews, and staff interviews the facility failed to initiate treatment orders on admission for a stage 3 pressure ulcer and once treatment orders were obtained, the facility failed to follow them. The resident was admitted to the facility with a stage 3 pressure ulcer and went 3 days before receiving treatment for 1 of 1 sampled resident (Resident #266). The facility was cited for F-314 in June 2016 for failing to implement hand rolls to prevent a pressure ulcer for a resident with a contracture. b. F-371 Based on observations and staff interviews the facility failed to keep two of two nourishment room microwaves clean for use.	F 520	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Corrective Action: Cross reference Tag F520 to Tag F314 Resident #266 Resident #266. Physician was notified on 5/24/2017. New physician orders placed and initiated as ordered. Resident and Resident's representative notified on 5/24/2017. Care plan was updated on 5/24/2017. Cross Reference Tag F520 to Tag F371 No residents identified No specific resident is identified. Cross Reference Tag F520 to Tag F431 No residents identified 100 and 400 hall Medication carts where locked and secured while the nurse was not in attendance. Medications were immediately secured properly. Cross Reference Tag F520 to Tag F441 Resident #255 and Resident #266 Resident # 255 Medication was administered as ordered maintaining standard precautions during medication administration. Resident #266 Hand washing was performed after Incontinence care was provided, maintaining standard	

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F 520	Continued From page 59 The facility was cited for F-371 in May 2016 for failing to store perishable food at safe temperatures, failing to keep ingredient bins clean and failing to store food items past the use by date. c. F-431 Based on observations, staff interviews and record review the facility failed to lock 2 of 4 medication carts (100 and 400 Halls) when left unattended. The facility was cited for F-431 in May 2016 for failing to label open insulin and failing to lock a medication cart when left unattended. The facility was recited for F-431 in June 2016 for leaving medications unattended at the nurses' station and failed to secure a medication cart when left unattended. d. F-441 Based on observations, record reviews, and staff interviews the facility staff failed to wash hands after performing finger stick glucose test and after performing incontinent care for 2 of 3 residents (#255 and #266). The facility was cited for F-441 in May 2016 for failing to maintain an infection control program that prevented the spread of scabies. On 05/25/17 at 3:42 PM the Administrator was	F 520	precautions Facility immediately in serviced all Nursing staff (RN, LPN, CNAs and Med Techs: Full time, Part Time and PRN) about infection control, preventing spread of infection during medication administration. To ALWAYS maintain standard precautions during medication administration and to always wash their hands when resident contact is made after performing incontinence care. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Cross reference Tag F520 to Tag F314 Resident #266 All residents have the potential to be affected by the alleged practice. On June 2 to June 16 2017 a skin assessment was completed on all residents to ensure that all pressure and non-pressure wounds were identified, physician was notified, and physician orders were followed and initiated. All care plans were updated. All pressure and non-pressure wounds were initiated as ordered. Skin assessments were completed by ADON and staff nurses. The wound review meeting was held on 6/15/17 by the Nurse Management Team (Director of Nursing, MDS, NHA, Unit Manager and Support Nurse). All physician orders were followed and initiated as ordered. Cross Reference Tag F520 to Tag F371 No residents identified All residents residing in the facility have potential to be affected. The facility is to ensure that dietary staff maintain	

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F 520	Continued From page 60 interviewed about the facility's Quality Assurance (QA)Program. The Administrator explained the QA Committee met monthly to review ongoing areas identified for concern and identify new areas that needed improvement. The Administrator stated that tags cited from the last annual recertification survey and follow-up survey had been incorporated into the QA committee agenda but had since been discontinued because she felt the facility was in substantial compliance with the tags.	F 520	nourishment room microwaves, all food preparation and service equipment clean and properly stored. Cross Reference Tag F520 to Tag F431 No residents identified All residents have the potential to be affected by the alleged practice. Audits were done by DON on 6/14/17 and all medication and treatment carts were locked and secured when the nurse was not in attendance. All medications were stored and secured. All medication and treatment carts are locked at all times when not in immediate use by Nurse. All Medication and treatment carts and also any area that medication was securely stored were checked to ensure that there was, no expired, undated or not initialed, open insulin by the nurse. Cross Reference Tag F520 to Tag F441 Resident #255 and Resident #266 All residents have the potential to be affected by the alleged practice. Director of Nursing observed Medication Administration Passes on Nurses (RN, LPN and Med Techs). All residents medications administered as ordered maintaining standard precautions and/ contact isolation during medication administration. Director of Nursing observed hand washing after Certified Nursing Assistant Performed incontinence care. All certified nursing assistant's staff observed washed hands after performing incontinence care. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, Medication Aides, CNAs full time, part	

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F 520	Continued From page 61	F 520	time, and PRN) that : Cross reference Tag F520 to Tag F314 Resident #266 Director of Nursing and /or Designee in serviced all Nurses (RNs, LPNs, full time, part time, and PRN) on the fact that when it comes to Skin integrity, specifically Pressure ulcers. Based on the comprehensive assessment of a resident , the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing . All Nurses (RNs, LPNs, full time, part time, and PRN) were also educated on the fact that it is the nurse's responsibility to notify physician, follow and initiate Physician orders. Physician should be called 24 hours a day and 7 days a week. This process does not change due to time or day of the week. Physician phone numbers orders are located at each nurse's station in the notebook. If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes then the nurse is to contact the DON immediately for further	

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F 520	Continued From page 62	F 520	instructions. Cross Reference Tag F520 to Tag F371 No residents identified The Registered Dietitian & Dietary Services Director in serviced all Dietary staff on insert dates regarding proper cleaning of microwaves and service equipment to ensure that all equipment is clean, free from grease, properly air dried and stored. An initial audit tool was put into place insert date. A follow-up in service on Preparing, Storing and Serving Food Under Sanitary Conditions was conducted for all Dietary staff on insert date by the Registered Dietitian. Any dietary employee who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees. A comprehensive audit tool was put into place to monitor compliance insert date. Cross Reference Tag F520 to Tag F431 No residents identified Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that 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. The facility must also separately lock, and have permanently affixed compartments for storage of controlled drugs. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles,	

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F 520	Continued From page 63	F 520	and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This in service was completed by 6/14/2017. Cross Reference Tag F520 to Tag F441 Resident #255 and Resident #266 Director of Nursing and /or Designee in serviced all Nursing staff (RN, LPN, CNAs and Med Techs: full time, part time, and PRN) about infection control, preventing spread of infection during medication administration and during and after performing incontinence care. The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;(2) Decides what procedures, such as isolation, should be applied to an individual resident; and(3) Maintains a record of incidents and corrective actions related to infections.(b) Preventing Spread of Infection(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.(2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is	

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 64	F 520	indicated by accepted professional practice.(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Medications are administered at the time they are prepared. Medications are not pre-poured. The person who prepares the dose for administration is the person who administers the dose. Hand hygiene should be performed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications. All staff were educated on contact isolation and the use of PPE. Always observe Standard Precaution and/or contact isolation during any medication administration. Wash hands if resident contact is made. Wash hands before and after resident contact. Wash hands when soiled. Standard Precautions should be used with all procedures involving blood or other potentially infectious body fluids. Ointments and drops should be kept in separate containers labeled with the resident's name. Liquid and PO medications should be stored separately in the medication carts. No medications used for treatments such as creams should be kept in the medication cart. These items should be kept in the treatment cart. Any medication used for the treatment of a resident who is on isolation precautions should be stored separately from other resident's treatment supplies and should be locked to prevent unauthorized access. Medication carts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 65	F 520	shall be cleaned when visibly soiled. Food and utensils shall be handled in a sanitary manner. Unused medication cups shall be kept covered or inverted. Sharps containers on medication carts shall be affixed or secured to prevent spillage. When administering oral medications, never touch pills or tablets with bare hands. If blister pack medications are prepared by pharmacy, punch the medication directly into a medication cup for dispensing. If tablets are in a bottle, then pour the medication into the lid and then transfer ordered dose into the medication cup. Clean any spilled liquid medication immediately. When administering eye drops, Always wear gloves. Wash hands after administration. Ensure that eye medication dispensers/containers do not touch the resident's eyes. If eye secretions are present, cleanse the lid with saline. Always wipe from the inner canthus outward. Always use separate tissue wipes or cotton balls for each eye to prevent cross contamination. When administering injections, Always wear gloves. Wash hands after administration. Use sterile technique when preparing the medication for injection. Cleanse the site with an antiseptic prior to administration of the injection. Dispose of the sharp in an appropriate container immediately following administration. Monitor the injection site for sign and symptoms of infection. When administering medications via syringe, the syringe should be used for	

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F 520	Continued From page 66	F 520	one resident only. Syringe shall be changed at least every 24 hours. Syringe shall be rinsed thoroughly, separated and dried thoroughly after each use and placed in cover by bedside or in a plastic bag, which is attached to feeding pole ready for next use. Wash hands before and after resident contact. Wash hands when soiled. Wash hands after performing incontinence care. A facility must maintain a quality assessment and assurance committee consisting of them director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This in service was completed by June 14th, 2017. Any Nurse (RNs, LPNs, full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into	

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F 520	Continued From page 67	F 520	the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, Administrator or Director of Nursing will monitor this issue using the QA survey tool. Facility will monitor compliance of QA for F314, F371, F431 and F441. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: June 16th 2017	