STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345216	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330

(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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide privacy	F 583	F583 Personal Privacy/Confidentiality The plan for correcting the specific	4/19/18

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

Electronically Signed | 04/06/2018

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F 583	Continued From page 1 during care for 1 of 1 sampled resident observed (Resident # 27). Findings included: Resident #27 was admitted to the facility on 7/27/17 with multiple diagnoses including hypertension and aphasia. The quarterly Minimum Data Set (MDS) assessment dated 2/2/18 indicated that Resident #27 had severe cognitive impairment and had a feeding tube. On 3/21/18 at 10:00 AM, Resident #27 was observed during the medication pass. Nurse #7 was observed to pull the resident's shirt up and his covers down exposing his abdominal area and his disposable brief prior to administering the medications via Gastrostomy (G) tube. Resident #27's bed was near the entrance door. The entrance door was wide open and the privacy curtain was not pulled. On 3/21/18 at 10:10 AM, Nurse #7 was interviewed. She stated that she should have provided privacy by closing the door during the medication administration but she did not. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to provide privacy during the medication administration via G tube by closing the door or pulling the privacy curtain.	F 583	deficiency and the process that led to the alleged deficiency: On 3/21/18 the Director of Nurses re-educated Nurse#7 on facility policy related to the provision of privacy during resident care and medication administration with return demonstration of Nurse#7 practice observed by the Director of Nurses. Procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/26/18, the Director of Nursing began re-education, with observation by return demonstration, of all full time, part time and per-diem nurses. Education will be focused on the provision of privacy by all nurses during medication administration or resident care. All full time, part time and per-diem nurses will be re-educated with observation by the Director of Nurses by 4/19/18 The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and or in compliance with the regulatory requirements: The Director of Nurses will randomly observe nurse practice for adherence to the provision of privacy during medication administration and resident care. This will be done on all shifts including weekends. The Director of Nurses will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x4 then monthly x3. The Director of Nursing will present reports to the Administrator weekly,that in turn will be shared with the Quality Assurance	

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F 583	Continued From page 2	F 583	Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attend the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction is The Director of Nurses.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to implement their written policy and procedure for investigating and reporting of an injury of unknown origin (UKO) for 1 (Resident #224) of 1 sampled resident reviewed for injury of UKO. The findings included:	F 607	F607 Develop/Implement Abuse/Neglect Policies On 3/22/18 the Director of Nurses assessed 100% of all current residents with any injuries of unknown origins including: bruises,skin tears, abrasions	4/19/18

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F 607	Continued From page 3 Review of the facility policy titled "Abuse Prohibition" dated last revised November 2017 read as follows: The Administrator or designee will investigate of any areas of concern. Included on the areas of concerns was injuries of UKO. Any injuries of UKO must be reported to the Health Care Personnel Registry via the 24-hour and 5-day report. Resident #224 was admitted 01/27/18 with cumulative diagnoses of osteoporosis and a history of a fall with left hip fracture. Resident #224 was care planned 01/29/18 for increased risk for fall related to gait and balance problems. There was no care plan for an actual fall. Resident #224 admission Minimum Data Set (MDS) dated 02/03/18 indicated moderate cognitive impairment with no behaviors. He was coded for extensive assistance with bed mobility and transfers. Review of Resident #224's medical record indicated he was out of the facility on 02/14/18 at the Orthopedic office and out of the facility again on 02/15/18 at the Urologist office. Review of the Situation, Background, Appearance, Review and Notify (SABR) report dated 02/15/18 at 4:00 PM, indicated Resident #224 was experiencing new pain and an x-ray was ordered. Review of a nursing note dated 02/16/18 at 1:49 AM read Resident #224 complained of pain with movement and the left hip appeared swollen.	F 607	and wounds. No other concerns were identified that met reporting requirements to Department of Health and Human Services, Division of Health Service Regulation. Procedure for implementing the acceptable plan of correction: On 3/22/18 the Nurse Consultant re-educated the facility Administrator and Director of Nurses on facility policy related to investigation and reporting of injuries of unknown origin. The re-education focused on the investigation process and reporting regulations required for injuries of unknown origin. Inservice education began on 3/26/18 by the Director of Nursing for all RNs, LPNs, Medication Aides, and Nursing Assistants, Full time, Part Time, and Per-diem employees related to facility abuse/neglect policies. The inservice topics included: Abuse & Neglect, and reporting requirements. The Director of Nursing will ensure that all above required employees will receive this training by 4/19/18. The title of the person responsible for implementing the acceptable plan of correction is the Administrator.	

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F 607	Continued From page 4	F 607		

Review of a nursing note dated 02/16/18 at 6:39 AM read Resident #224's x-ray report indicated a dislocated left hip. Orders were received to send Resident #224 to the hospital.

There was no evidence of an incident report completed for Resident #224 from his admission to the facility on 01/27/18 to his readmission to the hospital on 02/16/18.

Resident #224 was readmitted to the facility on 02/19/18 with a diagnosis of a closed dislocated left hip.

Resident #224 readmission MDS dated 02/26/18 indicated he sustained no falls.

In an interview on 03/20/18 at 12:15 PM, Resident #224 stated he had no falls while at the facility. He confirmed he had been taken to two physician visits by the facility transportation service but could not state how or when he left hip was dislocated.

In an interview on 03/20/18 at 5:20 PM, the Director of Nursing (DON) confirmed Resident #224 experienced no falls prior to the dislocation of his left hip. She stated she and management felt his hip must have gotten dislocated while he was out at one of his follow-up appointments. She stated there was no investigation or reporting completed.

In an interview on 03/21/18 at 2:43 PM, the Administrator stated she did not have evidence of an investigation or a 24-hour or 5-day report submitted to the Health Care Personnel Registry involving Resident #224's left hip dislocation.

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F 607	Continued From page 5 In another interview on 03/21/18 at 4:45 PM, the Administrator stated she did not think Resident #224's left hip dislocation as an injury of UKO therefore she did not investigate or report it. She stated it was her expectation that all injuries of UKO be investigated and reported as stated in the facility policy.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		4/19/18

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F 656	Continued From page 6 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to implement the comprehensive care plan for hydration/fluid restriction and intervention to monitor and document the intake and output for Resident #26. The facility also failed to develop a care plan for new psychotropic medications for Resident #228 and Resident #224. This was for 3 of 14 sampled residents reviewed for care plan development and implementation. Findings include: 1. Resident #26 was admitted to the facility from the hospital on 8/12/17. Physician order dated 8/25/17 revealed fluid restriction 1500 cubic centimeters (cc) per day 720 ccs from dietary and 780 ccs from nursing (390 ccs day shift and 390 ccs on night shift). The quarterly Minimum Data Set dated 2/1/18 revealed Resident #26 had adequate hearing and was understood and understands. The resident	F 656	The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Resident #224 February 2018 MAR revealed that she was on the medication Remeron for diagnosis of Depression that was prescribed for her on 2/9/18. There was no active care plan for the antidepressant medication. The care plan had been revised on 3/6/18 and on 3/15/18 she was prescribed Zoloft, an antidepressant medication. None of the two medications had been added to the care plan which had been reviewed on 3/10/18 Resident #26 had an order for fluid restriction for 1500cc per day. 720cc from dietary and 780cc from nursing (390cc from day shift nursing and 390cc from night shift). There was not adequate communication between the nurses and nursing assistants working with the resident as to how much fluid they would each provide for the resident and document accurately the amount of fluid	

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F 656	Continued From page 7 had a severely impaired cognition. The resident required one-person limited assistance for activities of daily living and set up for meals. The resident's diagnoses were obstructive uropathy, hyponatremia, non-Alzheimer's dementia, and benign prostate hypertrophy with bladder neck obstruction. A review of Resident #26 ' s care plan dated 2/23/18 revealed the resident had goals and interventions for potential dehydration related to hyponatremia and a fluid restriction of 1500 ccs per day. The goal was to comply with the fluid restriction. The intervention was for a 1500 cc fluid restriction per day and for staff to monitor and document intake and output. On 3/20/18 at 10:35 am an interview was conducted with Nurse #7. Nurse #7 stated she was assigned to Resident #26. Nurse #7 read the physician order and stated that the resident had a fluid restriction of 1500 cc per day, 720 ccs from dietary and 780 ccs from nursing. Nurse #7 stated that she did not document how much fluid the resident drank, which included during medication pass. Nurse #7 stated that she thought the nursing assistant charted the intake and output. Nurse #7 asked NA #7 where the intake was charted and NA #7 was not sure where, but in the past an option opened on the kiosk screen if the documentation was required. On 3/20/18 at 10:40 am an interview was conducted with NA #7 and indicated she was not aware Resident #26 had a fluid restriction. NA #7 stated and demonstrated that the resident ' s kiosk nursing assistant charting did not have an option to document intake and output. NA #7 opened the kiosk electronic charting and stated	F 656	the resident had consumed. This included how much the resident consumed during medication pass and any fluid provided any time during each sift with accurate documentation. Procedure for Implementing the acceptable plan of correction for the specific deficiency cited: The MDS Coordinator added the new medications to the care plan for the two residents on 3/20/18 when the surveyor alerted her on the care plan update issue. The MDS Consultant re-educated the MDS nurses on reviewing all new physician orders and updating the care plans as indicated. All new orders will be printed out and given to the MDS nurses daily during clinical meetings. The MDS nurse will review them and update the care plans as indicated on the orders. The Director of Nursing re-educated the nurses and the nursing assistants on accurately identifying all the residents who are on fluid-restriction, how much fluid restriction they are on, how to accurately measure each amount the resident consumed and communicate this information to the nurses. The nurses will document on the designated report. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nursing and MDS Nurses will review 3 residents using the QA audit tool for care plan revision and update weekly x 4 then monthly x 3. Reports will be presented to the Administrator weekly that in turn will	

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F 656	Continued From page 8 there was no place to document the intake and would not know how much the resident drank. NA #7 stated she did not know how much fluid the bedside cup held when full. On 3/20/18 at 10:50 am an interview was conducted with the Dietary Manager. The Dietary Manager stated that Resident #26 was on a fluid restriction of 1500 cc per day and that was split with nursing. Dietary provided 8 ounces/240 ccs on each of three trays each day. The resident ate meals in his room and nursing was required to document the fluid intake. On 3/20/18 at 1:45 pm an interview was conducted with Nurse #7. Nurse #7 stated that the facility- provided, covered cup for Resident #26 was measured and held 960 ccs. The nursing assistant filled the cup with ice and water on day and evening shifts each day. On 3/21/18 at 4:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the staff to implement the comprehensive care plan. 2. Resident #228 was admitted on 02/05/18 with cumulative diagnoses of Cerebral Vascular Accident (CVA), aphasia, dementia and right-side hemiplegia. Resident #228's admission Minimum Data Set (MDS) dated 02/12/18 indicated she had severe cognitive impairments with no behaviors. Review of Resident #228's March 2018 physician	F 656	be shared with the weekly QA committee by the Director of Nurse to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility QA process. The title of the person responsible for implementing the acceptable plan of correction: MDS Nurse and Director of Nursing	

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F 656	Continued From page 9	F 656		

orders indicated she was started on Ativan for anxiety on 03/06/18 and she was started on Zoloft for depression on 03/15/18.

Resident #228's care planned read it was last revised on 03/10/18. There was no care plan for depression or anxiety.

Interview on 03/20/18 at 4:52 PM, the MDS Nurse stated she was on vacation March 12, 2018 through March 16, 2018 and the MDS Assistant was covering for her that week. The MDS Nurse stated all physician orders were reviewed in their morning meeting and care planned accordingly.

Interview on 03/20/18 at 5:08 PM, the MDS Assistant stated she was covering for the MDS Nurse the week of March 12, 2018 through March 16, 2018. She stated the Director of Nursing (DON) brought all new orders to the morning meetings for review. She stated she did not recall any mention of new medications for Resident #228. The MDS Assistant stated she would have missed the newly prescribed antidepressant but not the antianxiety medication since that was prescribed on 03/06/18 when she was not covering for the MDS Nurse.

Interview on 03/20/18 at 5:13 PM, the MDS Nurse stated she did not care plan the antianxiety medication for Resident #228.

Interview on 03/20/18 at 5:20 PM, the DON stated she took all new orders to the morning meetings for review. She stated she did not recall the new orders for an antidepressant and an antianxiety medication for Resident #228. She stated it was her expectation that anytime a new psychotropic medication was prescribed, it should be care

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F 656	Continued From page 10 planned. 3. Resident #224 was admitted 01/27/18 with cumulative diagnoses of osteoporosis and a history of a fall with left hip fracture. Resident #224's admission Minimum Data Set (MDS) dated 02/03/18 indicated moderate cognitive impairment with no behaviors. Review of Resident #224's February 2018 physician orders indicated he was prescribed Remeron, an antidepressant on 02/09/18. Resident #224's care plan read it was last revised on 03/06/18. There was no care plan for the use of an antidepressant. Interview on 03/20/18 at 5:13 PM, the MDS Nurse stated she did not care plan the antidepressant prescribed for Resident #224 on 02/09/18. The MDS Nurse stated all physician orders were reviewed in their morning meeting and care planned accordingly. Interview on 03/20/18 at 5:20 PM, the DON stated she took all new orders to the morning meetings for review. She stated she did not recall the new orders for an antidepressant for Resident #224. She stated it was her expectation that anytime a new psychotropic medication was prescribed, it should be care planned.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		4/19/18

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F 657	Continued From page 11 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the comprehensive care plan for dehydration when the diuretic medication was discontinued for 1 of 14 sampled residents (Resident #31). Findings include: The resident was admitted on 10/5/13. The significant-change Minimum Data Set dated 2/12/18 revealed the resident had adequate hearing, was understood and understands. The	F 657	The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: Resident #31 had been care planned for at risk for dehydration related to use of diuretic medication. The physician order dated 1/21/18 revealed that the diuretic (Lasix 40mg) was discontinued. The resident's care plan dated 2/14/18 was still showing the diuretic medication and dehydration showing on the care plan. The focus problem should have been	

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	345216	A. BUILDING _____ B. WING _____	03/22/2018

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F 657	Continued From page 12 resident had memory deficit. The resident required extensive assistance of two persons for all transfers and one person for ADLs and meals. The resident's diagnoses were heart failure and multiple sclerosis. The resident was receiving Hospice services. The resident's care plan dated 2/14/18 revealed goals and interventions for bowel and bladder incontinence, decreased sensation secondary to MS, end-stage MS requiring increased assistance with activities of daily living, and dehydration or potential fluid deficit related to diuretic use. The physician order dated 1/21/18 revealed the Lasix 40 mg each day was discontinued. On 3/20/18 at 1:45 pm an interview was conducted with Nurse #7. Nurse #7 stated that the resident was provided assistance with food and hydration for all meals and at the time of incontinence care. Currently, the resident was taking sips and a few bites at a time. Nurse #7 stated that the resident no longer received a diuretic since January 2018 when Hospice services began. Nurse #7 indicated she was not aware that the resident was care planned for dehydration secondary to prescribed diuretic. On 3/21 at 4:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated she expected the comprehensive care plan to be updated when significant changes were made.	F 657	resolved from the care plan since it has been discontinued and was no longer active. The MDS Coordinator resolved the focus problem (dehydration/diuretic use) from the active care plan. All the residents with care plans with the focus for risk for dehydration and diuretic medication use were reviewed by the MDS nurses on 4/5/18. Care plans were revised and updated to reflect the current physicians orders. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/21/18 the MDS nurse consultant re-educated the MDS nurses on the care plan revision and updates as a daily practice and on as needed basis. All new orders are to be printed out and given to the MDS nurses daily during clinical meetings. The MDS nurse will review them and update the care plans as indicated on the orders. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The DON and MDS nurses will review 3 residents using the QA audit tool for care plan revision and update weekly x 4 then monthly x3. Reports will be presented to the Administrator which will in turn be shared with the weekly QA Committee by the Director of Nursing to ensure corrective actions for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, MDS Coordinator, Support Nurse, Therapy Director, Health Information Manager, Dietary Manager,	

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F 657	Continued From page 13	F 657	Administrator and Medical Director. Deficiencies that are identified during the monitoring process will be addressed through the facility QA process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to clarify the administration time for Flonase (used to treat allergies) (Resident #231) and failed to secure medications by leaving medications in resident's room (Resident #65) for 2 of 2 sampled residents observed. The findings included: 1. Resident #231 was admitted on 03/03/18. She was admitted with orders for Flonase two sprays in each nostril one time daily at bedtime. Observation of Resident #231's medication administration was completed on 03/21/18 at 8:50 AM with Nurse #1. Review of the March 2018 electronic Medication Administration Record (MAR) populated Resident #231's Flonase was scheduled to be administered at 9:00 AM. Nurse #1 did not	F 658	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 facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F658 Services Provided Meet Professional Standards Based on observation, staff interviews and record review, the facility failed to clarify the administration time for Flonase (used to treat allergies) (Resident #231) and failed to secure medications by leaving medications in resident's room (Resident	4/19/18

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F 658	Continued From page 14 administer the Flonase but rather stated she would call the physician for clarification of the time her Flonase was to be administered since the order read it was to be administered at bedtime. Review of the March 2018 MAR indicated Resident #231 had been receiving her Flonase at 9:00 AM rather than at bedtime as ordered. Review of the physician clarification order for Resident #231's Flonase indicated it was to be administered at 9:00 PM. Interview with on 03/21/18 at 12:45 PM, Nurse #6 stated when she entered Resident #231's Flonase orders, she mistakenly entered the administration time as 9:00 AM rather than 9:00 PM. Interview on 03/22/18 at 11:30 AM, the Director of Nursing (DON) stated it was her expectation Resident #231 receive her Flonase as ordered at bedtime or 9:00 PM. 2. Resident #65 was admitted to the facility on 9/23/15 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 2/28/18 indicated that Resident #65's cognition was intact. Review of the electronic health records (EHR) and hard copy chart revealed that Resident #65 was not assessed/care planned to self - administer medications. On 3/21/18 at 9:45 AM, Resident #65 was observed up in wheelchair in her room. There was a medicine cup with 5 tablets of medications	F 658	#65) for 2 of 2 sampled residents. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/21/18 The Director of Nurses re-educated Nurse#1 and #6 on facility policies related to clarification of medication orders and medication order entry. Nurse#6 was as well re-educated by the Director of Nurses on facility policy related to securing medications for resident safety. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/26/18, the Director of Nursing began re-education with observation by return demonstration of all full time, part time and per-diem nurses. Education was focused on facility policy related to securing medications, clarification of medication orders and medication order entry. All full time, part time and per diem nurses will be re-educated with observation by return demonstration by the Director of Nurses by 4/19/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses will randomly observe nurse practice for adherence to the securing of medications, clarification of medication orders and medication order entry. All full time, part time and per diem nurses will be re-educated with observation by return demonstration by the Director of Nurses by 4/19/2018	

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F 658	Continued From page 15 observed on top of the tray table. There was no nurse observed in the room or on the medication cart. On 3/21/18 at 9:55 AM, Nurse #6 was interviewed. She stated that she was the nurse assigned to Resident #65. Nurse #6 stated that she could leave medications in the room if a resident was alert and oriented. She acknowledged that she had left the morning medications of Resident #65 in the room. She indicated that she was distracted and forgot about it. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected nurses not to leave medications in the resident's room.	F 658	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses will randomly observe nurse practice for adherence to the securing of medications, medications order entry and medication order clarification process. This will be done on all shifts including weekends. The Director of Nurses will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nurses will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attend the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing.	
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life	F 675		4/19/18

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F 675	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner and Physician interviews and record review, the facility failed to provide timely assessment and interventions for a resident with a left hip dislocation for 1 (Resident #224) of 1 sampled resident reviewed for well-being. The findings included: Resident #224 was admitted 01/27/18 with cumulative diagnoses of osteoporosis and a history of a fall with left hip fracture. Resident #224 was care planned 01/29/18 for increased risk for fall related to gait and balance problems. There was no care plan for an actual fall. Resident #224 admission Minimum Data Set (MDS) dated 02/03/18 indicated moderate cognitive impairment with no behaviors. He was coded for extensive assistance with bed mobility and transfers. Review of Resident #224's medical record indicated he was out of the facility on 02/14/18 at the Orthopedic office and out of the facility again on 02/15/18 at the Urologist office.	F 675	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. F675 Quality of Life Based on observations, resident, staff, Nurse Practitioner and Physician interviews and record review, the facility failed to provide timely assessment and interventions for a resident with a left hip dislocation for 1 of 1 sampled residents reviewed for well being. Resident#224 The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/21/18 the Director of Nurses re-educated Nurse #1 and #2 on facility policy related to change in resident condition and timely initiation and follow	

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F 675	Continued From page 17 Review of an occupational therapy noted dated 02/15/18 read the therapist noticed Resident #224's left foot internally rotated. An attempt to reposition his foot resulted in pain. The note read the Rehabilitation Manager and nurse were aware of Resident #224 left hip concerns. Review of a physical therapy note dated 02/15/18 read Resident #224 presented with internal rotation of left hip and complaints of pain. The therapist was unable to realign correctly. Review of the Situation, Background, Appearance, Review and Notify (SABR) report dated 02/15/18 at 4:00 PM, indicated Resident #224 was experiencing new pain and an x-ray was ordered. Review of the x-ray electronic order was dated 02/15/18 read to be completed no later than 11:59 PM. Review of a nursing note dated 02/16/18 at 1:49 AM read Resident #224 complained of pain with movement and the left hip appeared swollen. Waiting for an x-ray of the left hip to be done. Review of the x-ray report indicated the x-ray was completed 3:56 AM and results were read and reported to the facility at 5:09 AM. Review of a nursing note dated 02/16/18 at 6:39 AM read Resident #224's left hip x-ray was completed at 4:00 AM and indicated a left hip dislocation. The physician was notified and orders obtained to send Resident #224 to the hospital. Resident #224 was readmitted to the facility on 02/19/18 with a diagnosis of a closed dislocated	F 675	through of stat physician orders for 3/17/18 through 3/21/18. 100% of residents were reviewed with 100% meeting compliance for timely assessment of change in condition. 100% review of stat orders and new orders for diagnostic test revealed compliance. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/26/18, the Director of Nurses began re-education of all full time, part time and per-diem nurses. Education will be focused on facility policy related to change in resident condition and timely initiation and follow through of stat physician orders. All full time, part time and per-diem nurses will be re-educated by the Director of Nurses by 4/19/18. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses will monitor for adherence to resident change in condition and the initiation and follow through of stat physician orders. The Director of Nurses will complete the Quality Assurance audit took for adherence to facility policy and process weekly x4 and then monthly x3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of	

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F 675	Continued From page 18 left hip. Resident #224 readmission MDS dated 02/26/18 indicated he sustained no falls. In an interview on 03/20/18 at 12:15 PM, Resident #224 stated he had no falls while at the facility. He confirmed he had been taken to two physician visits by the facility transportation service but could not state how or when he left hip was dislocated. In an interview on 3/21/18 at 11:30 AM, the Rehabilitation Manager stated she recalled a therapist talking about a significant change in Resident 224's left leg with a change in the position of his left foot. Her directive was to let his nurse know. In an interview on 03/21/18 at 11:50 AM, the occupational therapy assistant (OTA) and the physical therapy assistant (PTA) stated Resident #224 was fine the day before he went out to the Orthopedist. The PTA stated she spoke with Nurse #1 regarding her observed concerns with Resident #224's left foot. In an interview on 03/21/18 at 11:50 AM, the OTA stated his nursing assistant told her Resident #224 hurt his leg at the Orthopedic the previous day on 02/14/18. The OTA stated she also reported her assessment to Nurse #1. In an interview on 03/21/18 at 12:47 PM, the Nurse Practitioner (NP) stated she was available by phone between the hours of 8:00 AM and 5:00 PM Monday through Friday. She stated sometime after lunch, Nurse #1 contacted her about concerns related to internal rotation of Resident	F 675	Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager and Administrator will attend the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing	

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F 675	Continued From page 19	F 675		

#224's left leg. She stated she gave orders for a STAT (Immediate) x-ray. The NP stated normally the turn-around tine with a mobile x-ray provider was a few hours. She stated if the x-ray was not obtained until 3:56 AM on 02/16/18 and the nurses did not follow up on why the x-ray provider's status and location, that would be concerning.

In a telephone interview on 03/21/18 at 12:54 PM, the x-ray provider stated the order for a left hip x-ray was ordered and called in to their agency at 4:15 PM. She stated the order did not indicate it was STAT. She stated the x-ray technician arrived at 3:56 AM at the facility and resulted were called into the facility at 5:09 AM. She stated the report read Resident #224 had a left hip was dislocated.

In an interview on 3/21/18 at 1:49 PM, Nursing Assistant (NA) #1 stated she was assigned Resident #224 on 02/14/18 and she worked at double shift that day from 7:00 AM till 11:00 PM. NA #1 stated Resident #224 came back from the Orthopedic office and complained of left hip pain. She stated she assisted him to bed and thought she told his nurse. She stated she did not have to provide incontinence care to Resident #224 on second shift because he had a urinary catheter and did not requested to go to the bathroom. NA #1 stated she only checked him and repositioned him on second shift on 02/14/18. She stated on 02/15/18 when Resident #224 returned from an appointment with his Urologist, he was again complaining of pain and his left leg "looked weird." She stated she told Nurse #1 and she called his physician.

In an interview on 03/21/18 at 2:09 PM, Nurse #1

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F 675	Continued From page 20	F 675		

recalled it was early afternoon on 02/15/18 when she became aware of a problem with Resident #224's left leg. She stated assessed his left leg and noted internal rotation and swelling. She stated she contact the NP and she ordered a STAT x-ray. Nurse #1 stated she contact the x-ray provider and told them verbally about the need for the STAT x-ray. She stated there must have been miscommunication between her and the x-ray provider because it was to be done on 02/15/18. Nurse #1 stated when she reported off to Nurse #2 at 7:00 PM, she told her the x-ray still had not been done. She stated when she came in at 7:00 AM on 02/16/18, Nurse #2 was sending Resident #224 to the hospital.

In an interview on 03/21/18 at 3:05 PM, Physician #1 stated he and the NP were notified when Resident #224 began complaining about left hip pain. He stated his expectation that if x-ray was contacted at 4:00 PM and did not arrived by the end of Nurse #1's twelve-hour shift at 7:00 PM, there should have been follow up by Nurse #1 but before leaving or by Nurse #2 when she came on. He stated 12 hours was too long to wait for a STAT x-ray and he would have opted to send Resident #224 directly to the hospital rather than waiting to send him on 02/16/18.

In a telephone interview on 03/21/18 at 3:42 PM, Nurse #2 stated Nurse #1 reported to her that x-ray was coming to x-ray Resident #224's left hip. She stated she did not follow up with the x-ray provider because she understood that the x-ray provider was not coming until sometime on third shift. Nurse #2 stated she assessed Resident #224's left leg and noted that it "looked different and was swollen." She stated Resident #224 did not complain of pain but he was also in

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F 675	Continued From page 21 bed and not moving. She stated toward the end of her shift, the x-ray provider called and reported Resident #224's left hip was dislocated. She stated she contacted the physician and received orders to send him to the hospital. In an interview on 03/21/18 at 4:00 PM, Nurse #8 stated Resident #224 was transported to both of his follow up appointment on 02/14/18 and 02/15/18 using the facility contacted transportation service. She stated no incidents were reported by Resident #224 or the transporter. In an interview on 03/21/18 at 4:05 PM, NA #2 stated she worked second shift on 02/15/18 and Resident #224 did not complain of left hip pain but his leg did "look different" and Nurse #1 was aware. In an interview on 03/20/18 at 5:20 PM, the Director of Nursing (DON) confirmed Resident #224 experienced no falls prior to the dislocation of his left hip. She stated it was her expectation that when there is a change on the condition on any resident, it be reported the physician timely. She also stated it was her expectation that if there is an order for a STAT x-ray and they had not arrived within two-three hours, there should be follow-up with the x-ray provider to determine an estimated time or arrival or the physician be contacted about sending the resident out to the emergency room for an evaluation.	F 675		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		4/19/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 22 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, responsible party, resident and staff interviews and record review, the facility failed to provide showers as scheduled for 2 (Resident #228 and Resident #224) of 4 sampled residents reviewed for activities of daily living (ADLs). The findings included: 1. Resident #228 was admitted on 02/05/18with cumulative diagnoses of Cerebral Vascular Accident (CVA), aphasia, dementia and right-side hemiplegia. Resident #228's admission Minimum Data Set (MDS) dated 02/12/18 indicated she had severe cognitive impairments with no behaviors. She was coded as requiring total assistance with personal hygiene and bathing. Resident #228 was care planned on 02/06/18 for activities of daily living (ADLs) assistance due to her CVA. There was no care plan for the refusal of her ADLs. Review of the facility shower schedule for Resident #228 indicated she was to receive a shower every Wednesday and Saturday on first shift. Review of Resident #228's personal care records indicated she received one shower from 02/05/18 to 03/20/18. She was showered on 03/10/18. Interview on 03/21/18 at 8:05 AM, Nursing Assistant (NA) #5 stated she had never known Resident #228 to refuse any of her ADLs to	F 677	F677 ADL Care Provided for Dependent Residents Based on observation, record review, and staff, responsible party, resident interviews the facility failed to provide showers as scheduled for two of four residents sampled. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/22/18 the Director of Nurses audited all residents to ensure showers were given as scheduled or refusals were documented. On 3/22/18 The Director of Nurses and Support Nurse developed a process to assure that each resident received as shower as scheduled or refusal is documented. A process was developed to assure that any newly admitted or re-admitted residents will have a shower as scheduled unless contraindicated by physician order. On 3/22/18 the Director of Nurses re-educated NA#5 and NA#1 on facility policy related to showers. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/26 /2018, the Director of Nursing began re-education of all full time, part time, per-diem nurses and nursing assistants. Education will be focused on showering residents per the schedule unless contraindicated by physician order	

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	345216	A. BUILDING _____ B. WING _____	03/22/2018

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F 677	Continued From page 23 include showers. Interview on 03/21/18 at 1:49 PM, NA #1 stated she had never known Resident #228 to refuse any ADLs to include showers. Interview on 03/21/18 at 1:49 PM, NA #6 stated she had never known Resident #228 to refuse any ADLs to include showers. Interview on 03/21/18 at 4:20 PM, Resident #228's Responsible Party (RP) stated she was wondering why Resident #228 was not receiving any showers. She stated she had not inquired about why no showers were given to Resident #228. Interview on 03/22/18 at 9:35 AM, the Rehabilitation Manager stated occupation therapy was working on sponge bathing only with Resident #228. Therapy never assisted with showering Resident #228. Interview on 03/22/18 at 10:20 AM, NA #5 and NA #1 stated on the rehabilitation hall where Resident #228 was staying, each room has a personal shower. NA #5 stated she thought therapy stated it was unsafe to shower Resident #228 in the shower in her room. NA #5 stated they would have to take Resident #228 to the main shower room on the long-term care hall. NA #5 and NA #1 stated there was no directive not to take Resident #228 to the main shower room for a shower. Interview on 03/22/18 at 11:30 AM the Director of Nursing (DON) stated it was her expectation that all residents receive their showers as requested or scheduled. The DON stated the aides should	F 677	and documenting any refusals. As of 4/19/18 all full time, part time and per diem nurses and nursing assistants will be educated by the Director of Nurses on showering residents per the schedule unless contraindicated by physician order and documenting any refusals. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or delegate will randomly observe nursing assistant documentation for adherence to shower schedule. This will be done on all shifts including weekends. The Director of Nurses or delegate will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN assistant, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attend the Monthly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for	

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F 677	Continued From page 24 have taken Resident #228 to the main shower room on the long-term care hall for her showers. 2. Resident #224 was admitted 01/27/18 with cumulative diagnoses of osteoporosis and a history of a fall with left hip fracture. Resident #224 was care planned 01/29/18 for activities of daily living (ADLs) assistance. There was no care plan for any refusal of his ADLs. Resident #224 admission Minimum Data Set (MDS) dated 02/03/18 indicated moderate cognitive impairment with no behaviors. He was coded for limited assistance with personal hygiene and physical assistance required with bathing. Review of Resident #224's medical record indicated he was seen at the Orthopedic office on 02/14/18 and had his surgical staples removed. Review of Resident #224's medical record indicated he was sent to the hospital on 02/16/18 and readmitted to the facility on 02/19/18. Review of Resident #224's hospital discharge summary indicated he required no additional surgical intervention to his left hip. Review of the facility shower schedule for Resident #224 indicated he was to receive a shower every Tuesday and Friday on second shift. Review of Resident #224's personal care records indicated he received one shower from 02/19/18 to 03/20/18. He was showered on 03/01/18.	F 677	implementing the acceptable plan of correction: The Director of Nursing	

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F 677	Continued From page 25	F 677		

Interview on 03/20/18 at 12:15 PM, Resident #224 was sitting up in his wheelchair. He confirmed his surgical staples were no longer on his left hip. Resident #224 stated he could remember the last time he was given a shower. He stated a shower would "be nice."

Interview on 03/21/18 at 8:05 AM, Nursing Assistant (NA) #5 stated she had never known Resident #224 to refuse any of his ADLs to include showers.

Interview on 03/21/18 at 9:37 AM, NA #4 stated she had never known Resident #224 to refuse any ADLs to include showers.

Interview on 03/21/18 at 1:49 PM, NA #1 stated she had never known Resident #224 to refuse any ADLs to include showers.

Interview on 03/21/18 at 4:05 PM, NA #2 stated she had never known Resident #224 to refuse any ADLs to include showers.

Interview on 03/22/18 at 9:35 AM, the Rehabilitation Manager stated occupation therapy was working on sponge bathing only with Resident #224. Therapy never assisted with showering Resident #224.

Interview on 03/22/18 at 10:20 AM, NA #5 and NA #1 stated on the rehabilitation hall where Resident #224 was staying, each room has a personal shower. NA #5 stated she thought therapy stated it was unsafe to shower Resident #224 in the shower in his room. NA #5 stated they would have to take Resident #224 to the main shower room on the long-term care hall. NA #5 and NA #1 stated there was no directive not to

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F 677	Continued From page 26 take Resident #224 to the main shower room for a shower. NA #1 stated they could not shower any resident with surgical staples. NA #1 was reminded his surgical staples were removed 02/14/18. NA #1 stated Resident #224 could have been given a shower any time after 02/14/18. Interview on 03/22/18 at 11:30 AM the Director of Nursing (DON) stated it was her expectation that all residents receive their showers as requested or scheduled. The DON stated the aides should have taken Resident #224 to the main shower room on the long-term care hall for his showers after his staples were removed on 02/14/18.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to implement and document the ordered hydration/fluid restriction of 1500 cubic centimeters each day for 1 of 2 sampled residents reviewed for hydration (Resident #26) and Findings include:	F 684	F684 Quality of Care Based on observation, record review, and staff interview the facility failed to implement and document the ordered hydration/fluid restriction of 1500 cubic centimeters each day for 1 of 2 sampled residents reviewed for hydration. The plan for correcting the specific deficiency and the process that led to the alleged deficiency:	4/19/18

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F 684	Continued From page 27 1. Resident #26 was admitted to the facility from the hospital on 8/12/17. Physician order dated 8/25/17 revealed fluid restriction of 1500 cubic centimeters (cc) per day 720 ccs from dietary and 780 ccs from nursing (390 cc day shift and 390 cc on night shift). The quarterly Minimum Data Set dated 2/1/18 revealed Resident #26 had adequate hearing and was understood and understands. The resident had a severely impaired cognition. The resident required one-person limited assistance for activities of daily living and set up for meals. The resident's diagnoses were obstructive uropathy, hyponatremia, non-Alzheimer's dementia, and benign prostate hypertrophy with bladder neck obstruction. A review of Resident #26's care plan dated 2/23/18 revealed the resident had goals and interventions for potential dehydration related to hyponatremia and a fluid restriction of 1500 ccs per day. The goal was to comply with the fluid restriction. Intervention was for a 1500 cc fluid restriction per day and for staff to monitor and document intake and output. On 3/20/18 a review of Resident #26's electronic and paper record revealed fluid intake documentation could not be identified. On 3/20/18 at 9:30 am an observation was done of Resident and the facility-provided, covered full cup of water and ice with a straw was on the bedside table. On 3/20/18 at 10:30 am an interview was conducted with nursing assistant (NA) #8. NA #8	F 684	On 3/20/18 the Director of Nurses re-educated Nurse #7 and Nursing Assistant #8 on facility policy related to review of the resident's kardex and documentation of fluid intake for residents with orders for restricted amounts of fluids. On 3/21/18 the Director of Nurses reviewed all residents with fluid restriction orders and documentation of the ordered amount of restricted fluids. No other deficiencies were found. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/ 26 /2018, the Director of Nursing began re-education of all full time, part time, per-diem nurses, and nursing assistants. Education will be focused on documentation of fluid intake for residents with ordered fluid restrictions and review of resident kardex prior to the initiation of care. As of 4/19/18 all full time, part time and per diem nurses, medications aides and nursing assistants will be educated by the Director of Nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or designee will randomly audit practice for adherence to facility policy on fluid restrictions and documentation of restricted fluids amounts.. This will be done on all shifts including weekends. The Director of Nurses will complete the Quality	

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F 684	Continued From page 28 stated she was not aware of Resident #26 ' s fluid restriction. NA #8 stated she filled the resident ' s facility-provided, covered bedside cup each day with ice and water. NA #8 stated she did not know how much fluid was in the bedside cup and did not record how much fluid the resident drank on day shift. On 3/20/18 at 10:35 am an interview was conducted with Nurse #7. Nurse #7 stated she was assigned to Resident #26. Nurse #7 read the physician order and stated that the resident had a fluid restriction of 1500 cc per day, 720 ccs from dietary and 780 ccs from nursing. Nurse #7 stated that she did not document how much fluid the resident drank, which included during medication pass. Nurse #7 stated that she thought the nursing assistant charted the intake and output. Nurse #7 asked NA #7 where the intake was charted and NA #7 was not sure where, but in the past an option opened on the kiosk screen if the documentation was required. On 3/20/18 at 10:40 am an interview was conducted with NA #7 and indicated she was not aware Resident #26 had a fluid restriction. NA #7 stated and demonstrated that the resident ' s kiosk nursing assistant charting did not have an option to document intake and output. NA #7 opened the kiosk electronic charting and stated there was no place to document the intake and would not know how much the resident drank. NA #7 stated she did not know how much fluid the bedside cup held when full. On 3/20/18 at 10:50 am an interview was conducted with the Dietary Manager. The Dietary Manager stated that Resident #26 was on a fluid restriction of 1500 ccs per day and that was split	F 684	Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attend the Monthly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing	

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F 684	Continued From page 29 with Nursing. Dietary provided 8 ounces/240 ccs on each of three trays, each day. The resident ate meals in his room and nursing was required to document the fluid intake. On 3/20/18 at 1:45 pm an interview was conducted with Nurse #7. Nurse #7 stated that the facility- provided, covered cup for Resident #26 was measured and held 960 ccs. The nursing assistant filled the cup with ice and water on day and evening shifts each day. On 3/21/18 at 4:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the staff to follow the physician order for fluid restriction and document the intake.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		4/19/18

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F 690	Continued From page 30 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to assess a urinary catheter insertion site for injury and failed to provide urinary catheter care as ordered for Resident #224. The facility also failed to secure a urinary catheter to prevent tension for Resident #174. This was for 2 of 3 sampled residents reviewed for urinary catheters. The findings included: 1. Resident #224 was admitted 01/27/18 with cumulative diagnoses of a left hip fracture and benign prostrate hypertrophy (BPN) with urinary retention. Resident #224 was care planned 01/29/18 for an indwelling urinary catheter. Interventions included catheter care every shift. Review of Resident #224's admission orders dated 01/27/18 read as follows: Catheter care	F 690	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 dates indicated 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	

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F 690	Continued From page 31 every shift. Review of Resident #224's January 2018 Treatment Administration Record (TAR) indicated staff were providing catheter care on first shift (7:00 AM-3:00 PM), second shift (3:00 PM-11:00 PM) and on third shift (11:00 PM-7:00 AM). Resident #224 admission Minimum Data Set (MDS) dated 02/03/18 indicated moderate cognitive impairment with no behaviors. He was coded for an indwelling urinary catheter. Review of a nursing note dated 02/16/18 at 6:39 AM Resident #224 to the hospital for a dislocated left hip. Resident #224 was readmitted to the facility on 02/19/18 with a diagnosis of a closed dislocated left hip. Review of Resident #224's February 2018 TAR indicated staff were providing catheter care on first shift (7:00 AM-3:00 PM), second shift (3:00 PM-11:00 PM) and on third shift (11:00 PM-7:00 AM). This order ended when Resident #224 was sent to the hospital on 02/19/18. Review of Resident #224's readmission orders dated 02/19/18 read as follows: Provide catheter care daily every day shift. Review of Resident #224's February 2018 TAR indicated staff were providing catheter care on first shift (7:00 AM-7:00 PM) only starting on 02/19/18. Review of Resident #224's March 2018 TAR indicated staff were providing catheter care on	F 690	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated 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 dates indicated F690 Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and staff interviews the facility failed to assess a urinary catheter insertion site for injury and failed to provide urinary catheter care as ordered for resident #224. The facility also failed to secure a urinary catheter to prevent tension for resident #174. This was for two of three sampled residents reviewed for urinary catheters. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/20/18 the Director of Nurses revised the catheter order to include the care and securing of the catheters for residents #224 and #174. The nurse aide task list was updated to include documenting every shift catheter care for all residents with indwelling catheters. On 3/20 /18 The Director of Nurses and Nurse Consultant developed a process to assure that each resident with a catheter	

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F 690	Continued From page 32 first shift (7:00 AM-7:00 PM) only. Observation of Resident #224's urinary catheter insertion site was conducted on 03/20/18 at 3:40 PM with Nurse #4. His leg strap was attached to his right leg and found down around the right calf. Observation of the brief and his catheter insertion site indicated a moderate amount of dried blood. Nurse #4 provided catheter care and stated it appeared no catheter care was completed on first shift (7:00-3:00 PM) by the nursing assistant (NA). She stated the NA's provided catheter care and were to report any evidence of blood to the nurse. She stated blood at the catheter insertion site could indicate trauma from pulling or tension on the catheter. She stated the NA's were to provide catheter on every shift. Nurse #4 stated the NA's worked eight hours shift so his catheter care should be done three times daily. In an interview on 03/20/18 at 4:00 PM, Nurse #8 stated urinary catheter care should be completed on every eight-hour shift by the NA's. She stated and changes in the appearance of a catheter insertion site should be reported to the charge nurse. In an interview on 03/20/18 at 4:52 PM, the MDS nurse stated the it appeared when Resident #224's was readmitted, his catheter care order was entered into the electronic TAR incorrectly. She stated his catheter care was indicated on the NA task for every shift but it was entered as information only and not as a task the NA's had to sign off on as completed. In an interview on 03/21/18 at 9:37 AM, NA #4 confirmed she worked with Resident #224 on 03/20/18 for first shift (7:00-3:00 PM). She stated	F 690	will have catheter care and securement documented every shift. A process was developed to assure that any newly admitted or re-admitted residents with a catheter will have the catheter care and securement ordered and documented every shift. On 3/20/18 the Director of Nurses re-educated Nurse #4, and Nurse #8, and NA #4 on 3/21/18 on facility policy related to catheter care with return demonstration of NA#4, Nurse #4 and Nurse #8□s practice observed by the Director of Nurses. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/ 26 /2018, the Director of Nursing began re-education, with observation by return demonstration, of all full time, part time, per-diem nurses, and nursing assistants. Education will be focused on catheter care and securement. As of 4/19/18 all full time, part time and per diem nurses will be educated by the Director of Nurses and will include a return demonstration of catheter care and securement. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or designee will randomly observe nurse and nursing assistant practice for adherence to catheter care policy. This will be done on all shifts including weekends. The Director of Nurses will complete the Quality	

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	345216	A. BUILDING _____ B. WING _____	03/22/2018

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F 690	Continued From page 33 she completed a bed bath on Resident #224 and changed his brief yesterday morning. She stated there was no blood evident on his old brief she removed the morning of 03/20/18. NA #4 stated toward the end of her shift on 03/20/18, she assisted Resident #224 to the bathroom. She stated she did not noticed any dried blood to his brief or at the urinary catheter insertion site at the time. She stated if blood was observed, it should be reported to the nurse. NA #4 stated the urinary leg strap should be maintained just above the knee to prevent tension on the catheter. In an interview on 03/22/18 at 11:30 AM the Director of Nursing (DON) stated it was her expectation that a catheter securement device should be maintained at the thigh to prevent tension, NA's should report any evidence of blood or trauma at the catheter insertion site and catheter care should be completed on every eight-hour shift. 2. Resident #174 was admitted to the facility on 3/6/18 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 3/13/18 indicated that Resident #174 had moderate cognitive impairment and has indwelling urinary catheter. Resident #174's care plan dated 3/8/18 was reviewed. One of the care plan problems was "I have indwelling catheter". The goal was "I will remain free from catheter related trauma through next review". The approaches did not include securement of the catheter tubing. On 3/20/18 at 11:20 AM and at 5:03 PM, Resident #174 was observed in bed. He has an indwelling catheter in place and the tubing was not anchored to prevent excessive tension on the	F 690	Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN assistant, Therapy Manager, Health Information Manager, Dietary Manager and Administrator attend the Monthly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing	

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F 690	Continued From page 34 catheter. On 3/20/18 at 5:10 PM, Nurse # 5 was interviewed. She stated that a leg strap was only used to secure the catheter tubing when there was a doctor's order. Nurse #5 added that Resident #174 was a new admit and he had no order for a leg strap/leg band. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to secure catheter tubing at all times.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		4/19/18

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F 732	Continued From page 35 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to have an accurate staffing information posted for 11 (March 6, 7, 8, 9, 12, 13, 14, 15, 16, 19 and 20, 2018) of 11 weekdays reviewed. Findings included: The daily staffing information posting was observed on 3/20/18 at 9:30 AM. The posting revealed that there were 3 Registered Nurses (RN) working on 7-3 shift, 2 on 7A-7P shift and 3 on 7P-7A shift. The staffing assignment was reviewed for 3/20/18. There were 2 RNs on 7A-7P shift and 3 RNs on 7P-7A shift scheduled. On 3/21/18 at 3:25 PM, Nurse #8 was interviewed. She stated that she was responsible for completing the staffing information for the weekdays (Monday thru Friday) and the weekend supervisor was responsible for the weekends (Saturday and Sunday). She stated that the 3 RNs on 7-3 shift Monday thru Friday were the	F 732	F732 Posted Nurse Staffing Information Based on record review, observation and staff interview, the facility failed to have an accurate staffing information posted for 11 out of 11 weekdays reviewed. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/21/18 the Director of Nurses and Support Nurse were educated by the Nurse Consultant on the guidelines for daily staffing posting. On 3/22/18 the Director of Nurses implemented the required changes to the daily staffing posting. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/26/2018, the Director of Nursing completed a new staffing posting sheet in accordance with the guidelines for the staffing posting. The monitoring procedure to ensure that	

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F 732	Continued From page 36 Director of Nursing (DON) and the 2 Minimum data Set (MDS) nurses. She added that she was told to include the DON and the 2 MDS Nurse on the staff posting information. The staff posting for March 6, 7, 8, 9, 12, 13, 14, 15, 16, 19 &20 were reviewed. There were 2-3 RNs listed under 7-3 shift. On 3/22/18 at 11:40 AM, the DON was interviewed. She stated that she was not aware that the DON and the MDS Nurses should not be included on the staff posting information. The DON further stated that she had corrected the staff posting today (3/22/18) by not including the DON and the 2 MDS Nurses.	F 732	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses will review the daily staffing posting for accuracy. This will be done daily during the week, and the weekend sheets will be reviewed Monday. The Administrator or designee will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN assistant, Therapy Manager, Health Information Manager, Dietary Manager and Administrator attend the weekly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Administrator and Director of Nursing	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		4/19/18

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F 759	Continued From page 37 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below by not following doctor's orders. There were 3 (Residents #27 & #8)errors of 25 opportunities for error resulting in a 12 % error rate. Findings included: 1. Resident #27 had a doctor's order dated 7/27/17 to flush the Gastrostomy (G) tube with 30 milliliter (ml) of water before and after medication administration On 3/21/18 at 10:00 AM, Resident #27 was observed during the medication pass. Nurse # 7 was observed to prepare and to administer the medications via G tube without flushing the tube with water prior to administering the medications. On 3/21/18 at 10:10 AM, Nurse #7 was interviewed. She stated that she should have flushed the G tube with 30 ml of water prior to administering the medication but she forgot. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to flush the tube with 30 ml water prior to administering the medication. 2 a. Resident #8 had a doctor's order dated 1/1/18 for Synthroid (used to treat hypothyroidism) 50 microgram (mcg) daily by mouth before a meal and on 3/17/18 for Augmentin (an antibiotic) 500-125	F 759	F759 Free of Medication Error Rate 5 percent or More Based on observation, record review, and staff, responsible party, resident interviews the facility failed to maintain the medication error rate at 5% or below. The plan for correcting the specific deficiency and the process that led to the alleged deficiency: On 3/22/18 the Director of Nursing educated Nurse #7 on proper procedure of gastrostomy tube medication administration and administering medications as ordered by physician or mid-level practitioner. On 3/22/18 the Director of Nursing and Support Nurse audited all patients for transdermal patch orders and observed patches were on or off as ordered by the physician. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 3/22/2018, the Director of Nursing began re-education of all full time, part time, per-diem nurses. Education will be focused on medication administration as ordered by physicians or mid-level practitioners, including gastrostomy tube medication administration. As of 4/19/18 all full time, part time and per diem nurses and nursing assistants will be educated by the Director of Nurses on medication administration as ordered by physicians or mid-level practitioners, including gastrostomy tube medication	

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F 759	Continued From page 38 milligrams(mgs) by mouth 1 tablet daily with food for 7 days for urinary tract infection (UTI). On 3/21/18 at 8:26 AM, Resident #8 was observed during the medication pass. Nurse #7 was observed to prepare and to administer the resident's medications including Synthroid and Augmentin. The breakfast tray was in front of the resident and she had not started eating yet. On 3/21/18 at 10:10 AM, Nurse #7 was interviewed. She stated that medication ordered with food should be given with food and medication ordered before meal should be given before meals. Nurse #7 acknowledged that Synthroid and Augmentin should not be administered at the same time but she did. She further stated that she would call the doctor and change the administration time for Synthroid to 6:30 AM. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to follow the doctor's orders to administer medications with food and before meals. 2 b. Resident #8 had a doctor's order dated 1/3/18 for Nitroglycerin (used to treat hypertension) patch 34 H 0.1 mgs/hr 1 patch transdermally once a day - on at 9 AM and off at 9 PM. On 3/21/18 at 8:26 AM, Resident #8 was observed during the medication pass. Nurse #7 was observed to prepare and to apply Nitroglycerin 1 patch to the right chest wall. Nurse #7 was also observed to remove an old	F 759	administration. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses or delegate will randomly observe medication pass for adherence to orders by physicians or mid-level practitioners. This will be done on all shifts including weekends. The Director of Nurses or delegate will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator weekly, that in turn will be shared with the Quality Assurance Committee to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Minimum Data Set RN assistant, Therapy Manager, Health Information Manager, Dietary Manager, Administrator and Medical Director attend the Monthly Quality Assurance Meeting. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing	

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F 759	Continued From page 39 Nitroglycerin patch from the resident's left chest wall. On 3/21/18 at 10:10 AM, Nurse #7 was interviewed. She stated that the Nitroglycerin patch applied on 3/20/18 at 9 AM should have been removed at 9 PM of 3/20/18 as ordered but it was not removed. On 3/22/18 at 11:40 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to follow the doctor's order to remove the Nitroglycerin patch at 9 PM.	F 759		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff, Nurse Practitioner and physician interviews and record	F 865	F865 QAPI Program/Plan, Disclosure/ Good Faith Attempt.	4/19/18

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F 865	Continued From page 40 review, the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification survey of 02/23/17. This was for four deficiencies recited during a recertification survey of 03/22/18 in areas of Comprehensive Resident Centered Care Plans at F656 (F279) and F657 (F280). Additional areas included Quality of Life at F675 (F309) and Quality of Care at F690 (F315). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings include: This citation is cross referenced to: F656 (F279) Based on record review, observation, and staff interview, the facility failed to implement the comprehensive care plan for hydration/fluid restriction and intervention to monitor and document the intake and output for Resident #26. The facility also failed to develop a care plan for new psychotropic medications for Resident #228 and Resident #224. This was for 3 of 14 sampled residents reviewed for care plan development and implementation. F657 (F280) Based on record review and staff interview, the facility failed to review and revise the comprehensive care plan for dehydration when the diuretic medication was discontinued for 1 of 14 sampled residents (Resident #31). F675 (F309) Based on observations, resident, staff, Nurse Practitioner and Physician interviews and record review, the facility failed to provide	F 865	The plan for correcting the specific deficiency and the process that led to the alleged deficiency: The procedure for implementing the QAPI program as an acceptable plan of correction for the specific deficiency cited: On 4/15/18, the Quality Assurance Nurse in-serviced the Administrator in reference to facility policy, related to Quality Assessment and Assurance committee, consisting at a minimum of (1). A facility must maintain a QAPI committee consisting of at minimum, (i) The Director of Nursing; (ii) The Medical Director or his/her designee,(iii) at least three other members of the facility staff, at least one of whom must be the Administrator, Owner, a Board Member or other individual in a leadership role .The Quality Assessment an Assurance committee must: 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; (iii)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 attempt by the committee to identify and correct quality deficiencies may not be used as a basis for sanctions.) The Administrator or designee will monitor for adherence to the QAPI program by	

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F 865	Continued From page 41 timely assessment and interventions for a resident with a left hip dislocation for 1 (Resident #224) of 1 sampled residents reviewed for well-being. F690 (F315) Based on observations, staff interviews and record review, the facility failed to assess a urinary catheter insertion site for injury and failed to provide urinary catheter care as ordered for Resident #224. The facility also failed to secure a urinary catheter to prevent tension for Resident #174. This was for 2 of 3 sampled residents reviewed for urinary catheters. Interview on 03/22/18 at 10:40 AM, the Administrator stated she did not know what failed in the areas of care planning. She stated there had been no staff turn-over in the Minimum Data Set (MDS) department and no new computer program changes. The Administrator stated she was unsure why there was a delay in the diagnostic testing for a resident with an obvious dislocated hip or how urinary catheters were an ongoing care issue.	F 865	completing the Quality Assurance audit tool weekly x 4 then monthly x 3. The Director of Nursing will present reports to the Administrator and the Quality Assurance Committee. The committee will review each item to ensure that corrective action for any identified trends or ongoing concerns are initiated and monitored as appropriate and followed through the QAPI program which identifies the area that requires improvement, developing a plan to correct, implementing the plan, auditing and reviewing outcomes, and adjusting the plan as needed. The Director of Nursing, Minimum Data Set Coordinator, Support Nurse, Therapy Manager, Health Information Manager, Dietary Manager, and Administrator will attend the weekly and monthly Quality Assurance Meeting. Deficiencies identified through monitoring, will be processed through facility Quality Assurance program. (Identify problem, create a plan, implement the plan, study results, and adjust as necessary.) Previous survey tags identified, will be brought before the QAPI committee on 4/19/and will be reviewed to identify the area that requires improvement, developing a plan to correct, implementing the plan, auditing and reviewing outcomes, and adjusting the plan as needed. The title of the person responsible for implementing the acceptable plan of correction: The Administrator	