STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING _____ B. WING _____	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK ROAD FAIRVIEW, NC 28730

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code Minimum Data Sets for 1 of 3 residents reviewed for restraints (Resident #65) and 1 of 1 resident reviewed for hospice (Resident #72). The findings included: 1. Resident #65 was admitted to the facility 10/24/16 with diagnoses which included global geriatric decline and chronic anxiety disorder. A review of a quarterly Minimum Data Set (MDS) dated 04/06/18 revealed section P0100 Physical Restraints coded bed rail used daily indicating the bed rail was a restraint. The definition of a physical restraint as stated in section P0100 specified in part a physical restraint was any manual method or physical or mechanical device adjacent to the resident's body which restricted freedom of movement. During an interview on 05/24/18 at 11:18 AM, MDS Coordinator #1 confirmed bed rail used daily was coded as a restraint. She further confirmed a full bed rail on one side of Resident #65's bed would not prevent freedom of movement and should not be considered a restraint. The MDS Coordinator stated coding the red rail as a restraint was an error. She was observed initiating the process of filing a corrected MDS.	F 641	483.20 Accuracy of Assessments. Facility policy states "The assessment must accurately reflect the resident's status." Resident #65. The bed rail was coded as a physical restraint in error on the MDS. There was a lot of confusion as new regulations came out as to whether the side rails were considered restraints and in what circumstances. After further clarification better guidelines were released the MDS coordinators have been retrained. A corrected MDS was filed at the time it was observed. Resident #72. The hospice services box was not checked on the MDS after hospice services were started. The care plan, interdisciplinary notes, care area triggers (CATS) were all completed for the resident addressing the hospice services and the terminal illness box was checked on the MDS. There was an oversight on the MDS Coordinators part to miss checking the Hospice box. A corrected MDS was filed at the time it was observed. Plan of correcting the specific deficiency: Retraining the MDS coordinator regarding correct use of side rails and importance of	6/15/18

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

Electronically Signed | 06/12/2018

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F 641	Continued From page 1 An interview with the Director of Nursing revealed she expected MDS coding to be correct. 2. Resident #72 was admitted to the facility 04/06/17 with diagnoses which included Alzheimer's, and anxiety. Review of a significant change Minimum Data Set (MDS) dated 04/13/18 assessed Resident #72 cognition to be moderately impaired with short and long term memory loss. The MDS section O0100/Special Treatments/Procedures/Programs was assessed as none of the above. Part of section O0100 would include hospice care received by residents. Review of the physician order dated 04/12/18 revealed a referral to hospice services. During an interview on 05/24/18 at 12:52 PM, the MDS Coordinator #1 explained a significant change was done for the resident due to hospice services. After reviewing section O0100, the MDS Coordinator #1 confirmed she had not checked hospice services and would do a modification/correction. During an interview on 05/24/18 at 12:55 PM, the Director of Nursing revealed she expected MDS coding to be correct.	F 641	accuracy of MDS information. Corrected MDS's were filed for the specific residents. Plan for implementing the plan of correction: MDS coordinator reviewed most recent MDS assessments for residents with physical restraints and any residents on hospice services to ensure that all were coded accurately. Monitoring Plan of Correction: Assistant Director of Nursing to monitor all residents with Physical Restraints or hospice services weekly to ensure that any MDS's done on the resident's during that time have been coded correctly. This has been integrated into the Quality Assurance Performance Improvement program where the corrective action will be evaluated for its effectiveness and changes to corrective action made as needed. Person responsible to implement: MDS Coordinator Person responsible to monitor compliance: Assistant Director of Nursing Corrective action completed: 6/15/18	
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 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		6/15/18

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F 677	Continued From page 2 by: Based on observations, record review, and staff interviews the facility failed to provide nail care to 2 of 5 residents reviewed for activities of daily living (Resident #16, and Resident #32). The findings included: 1. Resident #16 was admitted to the facility 02/16/18 with diagnoses which included Alzheimer's and abnormal posture. A 30-day Minimum Data Set (MDS) dated 03/16/18 assessed the resident's cognition to be moderately impaired. The MDS also assessed Resident #16's functional status as requiring extensive assistance from staff with activities of daily living including personal hygiene, transfers, toileting, and bed mobility. Review of the care plan dated 03/06/18 identified a impaired self-care performance deficit with acitivities of daily living. The care plan goal was for Resident #16 to demonstrate improvement in activities of daily living as evidence by dressing the upper body with setup assistance from staff. Interventions included staff assistance with dressing and undressing daily and to clean and trim nails as needed. An observation on 05/22/18 at 9:21 AM revealed Resident #16's fingernails on both the left and right hand were long and extended pass the finger. Debris was noted under the left hand thumbnail and black colored debris under the pinky, thumb, and index fingernails of the right hand. An additional observation on 05/23/18 at 10:41	F 677	483.24(a)(2) ADL Care Provided for Dependent Residents. Facility policy states, "facility will monitor and care for the nails of our residents." "Nails will be inspected and clipped after baths, checked for cleanliness daily by nurses and aides during contact with the residents." Resident #16. Nails were in need of cleaning and trimming. CNA was notified as soon as it was brought to administrations attention and the nails were trimmed. Staff did state that resident frequently refuses care including nail care but that it was not documented. Resident # 32 Nails were in need of cleaning and trimming. CNA had already cleaned and trimmed the nails before we were notified by the survey team. Nail care is usually done by a manicurist, the bath team, CNA's and nurses. The manicurist took two leave of absences since January for personal reasons and some recent staffing shortages resulted in less staff on the floor. The combination of this resulted in lack of appropriate nail care being done and management failed to identify the issue at the time. Plan of correcting the specific deficiency: Both resident's nails were cleaned and trimmed immediately. Retraining to CNA's including the bath teams of their responsibilities and review of the policies and procedures regarding nail care. CNA	

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F 677	Continued From page 3 AM revealed Resident #16's fingernails remained unchanged in appearance and continued to have debris under the nails. During an interview conducted on 05/24/18 at 10:49 AM, Nursing Assistant (NA) #1 confirmed the residents fingernails were long and needed to be cut/trimmed. NA #1 also revealed trimming and cleaning residents' fingernails was part of her responsibility. During the interview Resident #16 stated her fingernails were too long and she wanted them cut/trimmed. During an interview on 05/24/18 at 11:03 AM, the Director of Nursing (DON) revealed her expectations were for residents to have their nails trimmed and for staff to provide nail care. 2. Resident #32 was admitted to the facility 06/21/16 with diagnoses which included Alzheimer's and dementia. A quarterly Minimum Data Set (MDS) dated 03/02/18 assessed the resident's cognition to be intact and required supervision with staff assistance for personal hygiene, bed mobility, toileting, and transfers. The care plan identified Resident #32 had impaired physical mobility with a self-care deficit in activities of daily living. The goal was for the resident to maintain the ability to perform the current level of activities of daily living. Interventions included staff were to provide assistance with cleaning and trimming nails as needed. An observation on 05/22/18 at 8:47 AM revealed Resident #32's fingernails on the right and left	F 677	to document nail care in the "unscheduled care" section of AHT. Instructed that if resident refuses to have nail care done to inform the nurse so that it can be documented in the resident's record. Plan for implementing the plan of correction: DON/Designee to check all residents nails to make sure clean and trimmed and document. Monitoring Plan of Correction: Director of Nursing to monitor at least 10 resident's nails per week to ensure that nails are clean and trimmed. Documentation will be maintained and reviewed in the QA meetings. It is integrated into the QAPI program where the corrective action will be evaluated for effectiveness and changes to corrective action made as needed. Person responsible to implement and monitor: Director of Nursing Corrective action completed: 6/15/18	

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F 677	Continued From page 4 hand were long and extended pass the finger with brown debris underneath all the right hand fingernails. Debris was also noted under the left hand index, middle, ring, and thumb fingernails. During an interview on 05/22/18 at 8:47 AM, Resident #32 stated the fingernails were too long and looked awful. Resident #32 revealed staff had not offered to trim/cut the fingernails. An additional observation on 05/24/18 at 9:56 AM revealed Resident #32's fingernails remained unchanged in appearance and continued to have debris under the nails. During an interview on 05/24/18 at 10:54 AM, Nursing Assistant (NA) #1 explained she did not realize Resident #32's fingernails were long and needed to be cut/trimmed and it was part of her responsibility to check fingernails and ask the residents if they want their nails trimmed. During an interview on 05/24/18 at 11:03 AM, the Director of Nursing revealed her expectations were for residents to have their nails trimmed and for staff to provide nail care.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		6/15/18

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F 695	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to change the oxygen tubing for 2 of 2 Residents (#2 and #27). The Findings included: 1 A. A review of Resident's #2 physician readmission order dated 05/02/18 indicated oxygen tubing was to be changed every week. Resident #2 was admitted to the facility on 05/10/16 with a diagnosis of congested heart failure, and heart attack. During observations of oxygen tubing for Resident #2 on 05/21/18 at 9:00 AM, 05/22/18 at 10:10 AM, 05/23/18 at 1:00 PM and 05/24/18 at 9:00 AM the oxygen tubing was dated 05/11/18. B. Resident #27 was admitted to the facility on 01/27/18 with a diagnosis of stroke and hypertension. A review of Resident's #27 admission order dated 01/27/18 indicated oxygen tubing was to be changed every week. During observations of oxygen tubing for Resident #27 on 05/21/18 at 9:00 AM, 5/22/18 at 10:10 AM, 5/23/18 1:00 PM and 05/24/18 at 9:00 AM the oxygen tubing was dated 05/11/18. On 05/24/18 at 9:09 AM an interview was conducted with Nurse #4 who stated the oxygen tubing was changed out every week on Friday. The Nurse #4 confirmed when the oxygen tubing was replaced on Friday it was dated on the plastic	F 695	483.25(l) Respiratory/Tracheostomy Care and Suctioning. Facility policy states, "Change nasal canula tubing every week or as ordered." Resident #2 and #27. Nasal canula/Oxygen tubing was noted to be out of date and not changed. Unit Clerk who was responsible was called to transport a resident to a doctor's appointment and she failed to get all the oxygen tubing replaced. The tubing should have been replaced upon her return but was not. Plan of correcting the specific deficiency: The oxygen tubing was replaced on the specific residents at the time the survey team brought it to our attention. Retraining of Unit Clerk on oxygen tubing policies and procedures. Plan for implementing the plan of correction: DON/designee has checked the oxygen tubing on all residents requiring oxygen to ensure they have all been changed. Checking that oxygen tubing has been changed has been added to the nurse's treatment record so that they can ensure it was changed weekly and document. Monitoring plan of correction: Director of Nursing to monitor all oxygen tubing weekly and document to ensure that tubing was changed. Documentation will be reviewed in the QA meetings and it is	

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F 695	Continued From page 6 bag attached to the oxygen tubing. The interview further revealed the Unit Clerk was responsible for this task every week. On 05/24/18 at 9:13 AM an interview was conducted with Nurse #5 who stated their unit clerk was responsible for changing oxygen tubing, nebulizers and mist bottles every week on Friday. On 05/24/18 at 9:30 AM an interview was conducted with the Director of Nursing (DON) who stated oxygen tubing was changed weekly. The DON stated there was a physician order and an admission order and the oxygen tubing was to be changed weekly. Her expectation was for the oxygen tubing to be changed every week according to the physician's admission order. She indicated the oxygen tubing was dated on 5/11/18 and should have been changed on 05/18/18. On 5/24/18 at 1:03 PM an interview was conducted with the Unit Clerk who was responsible for replacing the resident's oxygen tubing. She indicated on 05/11/18 she was transporting resident's to their appointments and she failed to replace all the resident's oxygen tubing. The unit clerk confirmed the oxygen tubing was dated 05/11/18 and should have been changed on 05/18/18.	F 695	integrated to the QAPI program where corrective action will be evaluated for effectiveness and changes to corrective action made as needed. Person responsible to implement and monitor: Director of Nursing Corrective action completed: 6/15/18	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		6/15/18

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F 761	Continued From page 7 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to discard one expired opened vial of Humulin regular insulin that was dated 03/14/18 for 1 of 1 Resident (#13). The Findings included: A review of the manufacture's recommendation indicated after a vial of Humulin regular insulin was opened it was to be discarded after thirty one days. Resident #13 was admitted to facility on 02/01/17 with a diagnosis of diabetes mellitus. A physician's order dated 06/8/17 indicated Resident #13 was to receive Humulin regular	F 761	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals. Facility policy states "Medication in multi-dose vials may be used until the manufacturer's expiration date/for the length of time allowed by state law/according to facility policy for thirty days if inspection reveals no problems during that time." "The date opened and initials of person opening are recorded on the multi-dose vials". Resident #13. There was an opened vial of Humulin regular insulin dated 3/14/18 in the medication refrigerator. The resident did receive 10 units of Humulin R on 5/21/18 as indicated on the MAR. The	

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F 761	Continued From page 8 insulin ten units subcutaneously when blood glucose levels exceeded 400. On 05/22/18 at 3:00 PM Resident #13's Humulin regular insulin was observed in the 600 hall medication room refrigerator and was opened and dated on 03/14/18 A review of the medication administration record (MAR) revealed Resident #13 received Humulin regular insulin ten units on 05/21/18 at 4:30 PM per physician's orders and as indicated by Nurse #3's documentation on the MAR. On 5/22/18 at 3:00 PM an interview was conducted with Nurse #1 stated she thought the Humulin regular insulin expired twenty eight days after the vial was opened. She confirmed the Humulin regular insulin vial and box for Resident #13 was dated 03/14/18. On 5/22/18 at 4:00 PM an interview was conducted with Nurse #2 who stated the Humulin regular insulin vial and box for Resident #13 was dated 03/14/18 when it was opened. When Nurse #2 opened a new vial of insulin she confirmed she always dated the insulin vial and the box. On 5/23/18 at 10:00 AM an interview was conducted with Director of Nursing (DON) who verified Resident #13's Humulin regular insulin was opened and dated on 03/14/18. The DON stated her expectation was Resident #13's Humulin regular insulin should have been disposed of thirty days after the date it was opened. On 5/23/18 at 4:21 PM an interview was	F 761	pharmacy verified that he received a vial of Humulin R on 5/11/18 which is in the medication refrigerator as well and has been opened and used. Unsure if the expired insulin was actually given since it could have been drawn up from the newer bottle. But the expired bottle should have been discarded and was discarded as soon as it was brought to the nurses attention by the surveyor. Plan of correcting the specific deficiency: The expired insulin bottle was discarded immediately. Retraining to all nurses regarding the multi-dose vial policies and procedures. We added an addition to all insulin orders stating "vial dated when opened and used within 30 days of opening" to remind nurse's to double check all dates. Plan for implementing the plan of correction: DON/Designee checked all multi-dose vials to ensure they were dated when opened and in date. Monitoring Plan of Correction: Director of Nursing to monitor all multi-dose vials weekly to ensure they are dated when opened and discarded after 30 days. This will be documented and reviewed in the QA meetings and integrated into the QAPI program to ensure effectiveness of corrective action and make changes as needed. Person Responsible to implement and monitor: Director of Nursing.	

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F 761	Continued From page 9 conducted with the Consulting Pharmacist who verified Resident #13 received Humulin regular insulin according to physician orders. She also verified Humulin regular insulin expiration date was thirty one days after the vial of insulin was opened and was to be discarded.	F 761	Corrective action completed: 6/15/18	