STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

(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 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		7/26/18

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

Electronically Signed | 07/20/2018

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F 623	Continued From page 1 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 2 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: 2. Resident # 90 was readmitted to the facility on 04/01/2018 with diagnoses that included abdominal abscess, pressure ulcers, and post colectomy. A 5 day Minimum Data Set (MDS) dated 03/31/2018 coded Resident # 90 as moderately cognitively impaired. A nurse note dated 03/31/2018 at 9:01 PM revealed that the family of Resident # 90 met with the Hospice Nurse and that Resident # 90 was to be discharged to Hospice House on 04/01/2018. A physician (MD) transfer summary dated 04/02/2018 revealed that Resident # 90 was discharged to Hospice House 04/01/2018. An interview was conducted with the facility Admissions Coordinator (AC) and the Marketing Director on 06/28/2018 at 5:14 PM. The AC	F 623	THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficiency was a result of the facility not readily seeing and understanding the change that was made in the Federal Regulation that became effective on November 28, 2017. The facility has implemented a process that ensures that all residents and resident's representative(s) as well of the Ombudsman are notified of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility has developed a written Notice of Emergency Transfer form that contains the following information: 1. States the intent of the facility is to	

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F 623	Continued From page 3 revealed that when a resident was discharged to any outside entity and the discharge was planned the Ombudsman had not been notified of the discharge and written notification was not given to the resident's family because they were aware of the planned discharge. The AC and Marketing Director revealed that the Ombudsman was only notified of involuntary discharge. The AC and Marketing Director confirmed written notice of Resident # 90's discharge from the facility was not provided to the resident's family or the Ombudsman. On 06/28/2018 at 5:30 PM an interview was conducted with the AC, Marketing Director and the Administrator. The Administrator revealed that the facility staff was not aware of the regulation regarding Ombudsman notification that was effective 11/28/2017 for planned discharge from the facility. Based on record reviews, family interview, and staff interviews, the facility failed to notify the resident and Ombudsman in writing of the residents' discharge from the facility to the hospital for 2 of 2 residents reviewed for hospitalization, Resident #68 and Resident #90. Findings included: 1. A review of the medical record revealed Resident #68 was originally admitted to the facility on 5/12/18 and was readmitted to the facility on 5/19/18 with diagnoses which included: aspiration pneumonia, difficulty swallowing diabetes, and Parkinson's disease. Review Resident #68's Minimum Data Set (MDS) revealed an admission comprehensive	F 623	receive the resident back, after their medical or behavioral condition is stabilized, if they choose to return to the facility. 2. States the date and time of the transfer. 3. States the reason for the transfer and the location the resident is being transferred to and includes the name, address, and telephone number of the transfer location. 4. The transfer notice also includes instructions on their right to appeal the transfer. 5. The transfer notice also includes the Name, address, e-mail, and telephone of the local Long Term Care Ombudsman, as well as the State Long Term Care Ombudsman. 6. Provides contact information if mentally ill or developmentally disabled. 7. Provides documentation for date and time when notice was e-mailed or mailed to the resident or responsible party. 8. Provides documentation for date and time when notice was e-mailed or faxed to the Ombudsman. Once transfer becomes necessary, if possible this notice will be provided to the resident or responsible party. If the transfer occurs during non-business hours and the resident is not able to receive the notice or responsible party is not present the completed transfer notice will be included in the Acute Care Transfer Document Checklist packet that is sent with the resident to the receiving location. On the next business day the Social Worker or designee will mail or e-mail a	

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F 623	Continued From page 4 assessment with an Assessment Reference Date (ARD) of 5/26/18. Review of the assessment revealed the resident was coded as having had severe cognitive impairment. A review of a nurses' note completed by Nurse #1, dated 5/14/18 and timed 4:09 PM, revealed Resident #68 had been discharged to the hospital via Emergency Medical Services (EMS) at 3:40 PM on 5/14/18. The resident was documented as having been very drowsy, decreased level of consciousness, and lethargic. In addition, the nurses' note documented the resident had a critically high level of calcium at 12.9 and his White Blood Cells (WBCs) were increased. The resident's physician was notified and an order had been obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's family had been notified the resident was being sent to the ER. A Hospital Discharge Summary dated 5/19/18 revealed Resident #68 was admitted to the hospital on 5/14/18 with diagnoses of aspiration and respiratory failure. He was discharged back to the facility on 5/19/18. An interview was conducted with the facility Social Worker (SW) on 6/28/18 at 5:00 PM. The SW stated she had not notified the ombudsman verbally or in writing in regards to the discharge of Resident #68 to the hospital on 5/13/18. The SW stated she had only been notifying the ombudsman of a discharged if it was involuntary and had been initiated by the facility. The SW further stated she had not notified the resident's family verbally or in writing regarding the resident's discharge to the hospital or a bed hold	F 623	copy of the completed form to the resident/responsible party. Date and time of mailing or e-mail will be noted on the form. In addition the Social Worker or designee will e-mail or fax a copy to the Ombudsman with date and time notated on the form. A copy of this notice will be kept in the resident's medical file. In addition the facility has developed a written Notice of Planned Discharge form that contains the following information: 1. States that the facility is issuing the discharge notice because the resident and responsible parties are in agreement with the discharge, because the goals for their stay at Alston Brook have been met. 2. States the date and time of the discharge. 3. States the reason for the discharge and the location the resident is being discharged to. 4. The discharge notice also includes instructions on their right to appeal the discharge. 5. The discharge notice also includes the Name, address, e-mail, and telephone number of the local Long Term Care Ombudsman, as well as the State Long Term Care Ombudsman. 6. Provides contact information if mentally ill or developmentally disabled. 7. Provides a place for signature of the resident or responsible party to sign acknowledging receipt of the notice. 8. Provides documentation for date and time when notice was e-mailed or mailed to the resident or responsible party, if not available for signature. Once it is determined that discharge is	

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F 623	Continued From page 5 and the nurses were responsible for the notification. An interview was conducted with Nurse #1 on 6/28/18 at 5:10 PM. Nurse #1 stated she was the nurse who was assigned to Resident #68 on 5/14/18 on the date of his discharge to the hospital. She stated she called the resident's family and notified them verbally the resident was being discharged to the hospital. An interview was conducted on 6/28/18 at 5:14 PM with the Admissions Coordinator (AC) and the Marketing Director (MD). During the interview the AC stated when a resident was discharged to the hospital the MD would call the resident's family to verbally inform them about the resident's discharge to the hospital and inquire about a bed hold. The AC stated Resident #68's family was contacted, but had not chosen a bed hold during the resident's hospitalization. The MD stated she did not have any documentation in the medical record regarding her contacting the resident's family. The MD and AC stated they do not send any written notification to a resident's family regarding the resident's hospitalization after a resident is discharged to the hospital. The MD and AC stated they did not notify the Ombudsman in regards to a resident who has been discharged to the hospital. The MD and AC stated the only time they had notified the Ombudsman was when a resident was being involuntarily discharged. The MD stated the facility had not been providing written notification to resident's families when the resident was discharged to the hospital. An interview was conducted on 6/28/18 at 5:35 PM with the Administrator, Director of Nursing (DON), AC, and MD. The Administrator stated he	F 623	being conducted due to completion of planned stay with goals achieved or at the request of the resident, the notice of discharge will be given to the resident or responsible party having them sign to acknowledge the notice. If unable to sign the notice it will be e-mailed or mailed to the resident and/or responsible party. By July 26, 2018 the Long Term Care Ombudsman will be faxed a copy of all discharges which have occurred since November 1, 2017 through June 30, 2018 that indicate the Resident name and effective date of discharge. Henceforth, at the end of each calendar month a report will be produced that includes all discharges for that month and will be either e-mailed or faxed to the Long Term Care Ombudsman. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY CITED. In-service training of staff conducted by the Director of Nursing on the new process of issuing the Notice of Emergency Transfer and the Notice of Planned Discharge, as well as an explanation of the new regulation that took effect on November 28, 2017 will be completed no later than July 26, 2018. No later than July 26, 2018 The Notice of Emergency Transfer form will be added to the Acute Care Transfer Document Checklist indicating that Form is to be completed and given to or transported with the resident. In addition the Notice of Transfer/Discharge procedure will be utilized for all Transfers and Discharges.	

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F 623	Continued From page 6 and the staff were not familiar or aware a new regulation had taken effect as of 11/28/17 regarding notification to the Ombudsman for residents whom had been discharged to the hospital. The Administrator stated the facility had not been notifying the Ombudsman of residents whom had been discharged to the hospital. An interview was conducted on 6/28/18 at 7:24 PM with Resident #68's family. The family member stated she had not received written notification from the facility regarding the resident's discharge to the hospital. The family member did state someone from the facility had called her and mentioned the bed hold to her when the resident was in the hospital from 5/14/18 to 5/19/18.	F 623	The Social Worker or designee will maintain a file containing all Transfer Notices that have been issued and submitted to the Long Term Care Ombudsman, as well as a file containing the monthly reports of discharges submitted to the Long Term Care Ombudsman. In addition a copy of all transfer and discharge notices will be placed in the Resident medical record. By July 26, 2018 the Long Term Care Ombudsman will be faxed a copy of all discharges which have occurred since November 1, 2017 through June 30, 2018 that indicate the Resident name and effective date of discharge. Henceforth, at the end of each calendar month a report will be produced that includes all discharges for that month and will be either e-mailed or faxed to the Long Term Care Ombudsman by the Social Worker. 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 Administrator or designee will be responsible to complete a Quality Assurance Review for accuracy and compliance of the file containing all Transfer Notices that have been issued and submitted to the Long Term Care Ombudsman, as well as the file containing the monthly reports of discharges submitted to the Long Term Care Ombudsman on a weekly basis for four (4) weeks, then bi-weekly basis for four	

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F 623	Continued From page 7	F 623	(4) weeks, then on a monthly basis. On a quarterly basis the Administrator will report the findings and results to the Quality Assurance committee for monitoring and recommended changes. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION. The Administrator is responsible for implementing the acceptable plan of correction.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		7/26/18

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F 625	Continued From page 8	F 625		

hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, family interview, and staff interviews, the facility failed to provide written notification to the resident's family regarding bed hold when the resident was hospitalized for 1 of 2 residents reviewed for hospitalization, Resident #68.

Findings included:

A review of the medical record revealed Resident #68 was originally admitted to the facility on 5/12/18 and was readmitted to the facility on 5/19/18 with diagnoses which included: aspiration pneumonia, difficulty swallowing diabetes, and Parkinson's disease.

A review of a nurses' note completed by Nurse #1, dated 5/14/18 and timed 4:09 PM, revealed Resident #68 had been discharged to the hospital via Emergency Medical Services (EMS) at 3:40 PM on 5/14/18. The resident's physician was notified and an order had been obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's family had been notified the resident was being sent to the ER.

A Hospital Discharge Summary dated 5/19/18 revealed Resident #68 was admitted to the hospital on 5/14/18 with diagnoses of aspiration and respiratory failure. He was discharged back to the facility on 5/19/18.

THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED.
The processes that lead to the deficiency was a result of the facility not getting signatures of acknowledgement of Bed Hold Policy and noted election of the the Resident or responsible party. The facility was utilizing telephone calls and not maintaining proper documentation of resident or family election. The facility has implemented a process that ensures that all residents and resident's representative(s) are notified of the bed hold and return policy before or at the time of transfer to a hospital or the resident goes on therapeutic leave. The facility has developed a Bed Hold Policy and Consent Agreement form that contains the following information:
1. Defines the facility Bed-hold Policy in accordance with federal and state regulations.
2. Defines the process of holding a bed and what occurs if they choose not to hold a bed.
3. Defines their right to return to the facility even if they do not elect to pay to hold the bed.
4. Defines the initial number of days of

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F 625	Continued From page 9 An interview was conducted with the facility Social Worker (SW) on 6/28/18 at 5:00 PM. The SW stated she had not notified Resident #68's family verbally or in writing regarding a bed hold and the nurses were responsible for the notification. An interview was conducted with Nurse #1 on 6/28/18 at 5:10 PM. Nurse #1 stated she was the nurse who was assigned to Resident #68 on 5/14/18 on the date of his discharge to the hospital. She stated she called the resident's family and notified them verbally about the resident being discharged to the hospital. She further stated the Business Office Manager was the staff member who was responsible for the Bed Hold notification. An interview was conducted with the Business Office Manager (BOM) on 6/28/18 at 5:13 PM. The BOM stated she was not responsible for the bed hold notification. The BOM stated the Admissions department was responsible for providing residents and families information about the bed hold. An interview was conducted on 6/28/18 at 5:14 PM with the Admissions Coordinator (AC) and the Marketing Director (MD). During the interview the AC and MD stated they both took care of the bed hold. The AC stated the day after discharge the MD would call the resident's family and inquire about a bed hold. The AC stated Resident #68's family had not chosen a bed hold during his hospitalization. The MD stated she did not have any documentation in the medical record regarding her contacting the resident's family regarding the bed hold. The MD and AC stated they do not send any written notification to a	F 625	bed-hold and process for continued bed-hold. Once transfer becomes necessary, if possible this notice will be provided to the resident or responsible party at time of transfer. If the transfer occurs during non-business hours and the resident is not able to receive the Bed Hold Policy and Consent Agreement or responsible party is not present, the completed Bed Hold Policy and Consent Agreement will be included in the Acute Care Transfer Document Checklist packet that is sent with the resident to the receiving location. On the next business day the Admission Coordinator or designee will attempt to personally contact the resident or responsible party to ensure they received the Bed Hold Policy and Consent Agreement Form and give them opportunity to make their election on the Form. If the resident is not capable or the responsible party is not reachable the Admission Coordinator or designee will mail or e-mail a copy of the completed form to the resident/responsible party. Date and time of mailing or e-mail will be noted on the form. A copy of this notice will be kept in the resident's medical file. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY CITED. In-service training of staff conducted by the Director of Nursing on the new process of providing the resident or responsible party a copy of the Bed Hold Policy and Consent Agreement Form at the time of transfer, will be completed no	

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F 625	Continued From page 10 resident's family regarding a bed hold after a resident is discharged to the hospital. The MD stated the facility had not been providing written notification regarding the bed hold to resident's families when the resident was discharged to the hospital. An interview was conducted on 6/28/18 at 5:35 PM with the Administrator, Director of Nursing (DON), AC, and MD. The Administrator stated he and the staff were not familiar or aware a new regulation had taken effect as of 11/28/17 regarding providing written notification to a resident or their family for residents whom had been discharged to the hospital. The Administrator stated the facility had not been providing written notification to a resident's family or the resident themselves whom were discharged to the hospital. An interview was conducted on 6/28/18 at 7:24 PM with Resident #68's family. The family member stated she had not received written notification from the facility regarding a bed hold for the resident. The family member did state someone from the facility had called her and mentioned the bed hold to her when the resident was in the hospital from 5/14/18 through 5/19/18.	F 625	later than July 26, 2018. Effective July 20, 2018 The Bed Hold Policy and Consent Agreement form was added to the Acute Care Transfer Document Checklist indicating that the Form is to be completed and given to the resident or transported with the resident. The Admission Coordinator or designee will maintain a file containing all Bed Hold Policy and Consent Agreements that have been issued. In addition a copy of all completed Bed Hold Policy and Consent Agreements will be placed in the Resident medical record. 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 Administrator or designee will be responsible to complete a Quality Assurance Review for accuracy and compliance of the file containing all Bed Hold Policy and Consent Agreement Forms that have been issued. This will be conducted on a weekly basis for four (4) weeks, then bi-weekly basis for four (4) weeks, then on a monthly basis. On a quarterly basis the Administrator will report the findings and results to the QAA committee for monitoring and recommended changes. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION. The Administrator is responsible for	

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F 625	Continued From page 11	F 625	implementing the acceptable plan of correction.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to utilize left hand and arm splint for 1 (Resident # 35) of 1 residents reviewed for contracture. The findings included: Resident # 35 was readmitted to the facility on 06/07/2015 with diagnoses that included vascular dementia, depression, abnormal posture, functional quadriplegia and left elbow contracture. A review of a quarterly Minimum Data Set (MDS)	F 688	THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficiency was a result of the facility not having a check system in place to follow through with ensuring that splints/braces are applied consistently and accurately. The facility has implemented a triple check system to the Functional Maintenance Program. The Staff Development	7/26/18

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F 688	Continued From page 12 dated 04/19/2018 revealed that Resident # 35 was cognitively impaired and required extensive to total assist with activities of daily living (ADLs) and Resident # 35 was wheel chair bound and had functional limitation in range of motion (ROM) to both upper and lower extremities and had received occupational therapy (OT) services for 150 minutes for 5 days. A review of the care plans for Resident # 35 revealed a care plan initiated on 05/03/2018 that Resident # 35 received restorative therapy for passive range of motion (PROM) to the left upper extremity (LUE) to maintain current range of motion (ROM) and to reduce the risk of contracture development and ease of application of the splint and that Resident # 35 was to wear a left-hand splint and elbow splint for up to six hours. The care plan goal was that Resident # 35 would tolerate the PROM and splint program with no signs or symptoms of skin breakdown as evidenced by weekly skin checks through the next review. Interventions included to provide splint program at least 5 days a week for 3 to 6 hours a day, monitor skin for pressure or redness before and after splint worn, monitor contracture assessment quarterly and to notify therapy services of any changes. Interventions also included to monitor and document Resident #35 of progress in program and to praise Resident# 35 for program participation to give cues as needed and to provide PROM exercises as directed by the OT. A physician (MD) order dated 05/17/2018 revealed that Resident # 35 was to have OT evaluate and treat as indicated. Review of an OT order dated 05/17/2018	F 688	Coordinator will in-service the Certified Nursing Assistants and Nurses by July 26, 2018 on the policy and procedure for Splint training, application and documentation to ensure each splint is checked for proper placement and proper documentation and henceforth will be incorporated into the New Hire Orientation Program for Certified Nursing Assistants and Nurses. In addition the facility has re-titled the Restorative Certified Nursing Assistant to the title of Functional Maintenance Certified Nursing Assistant. The facility has also updated the Functional Maintenance Plan Form to included places for staff members to sign and a line for the date indicating when the splint will begin being applying. In addition Resident # 35 has been reevaluated and picked by Occupational Therapy. Initial Occupational Therapy evaluation indicated there had been no change in her range of motion or ability to wear her splint. Occupational Therapy will have completed all re-training of care staff no later than July 26th, 2018. The procedure for implementation is as follows: 1. As per facility Medical Director and Rehab Director Splint and brace applications are done Monday through Friday first shift (7am to 3:30pm) only. The Certified Nursing Assistant assigned to the resident is responsible for placement of splint/brace and documentation. 2. The Functional Maintenance Certified Nursing Assistant will be responsible to ensure that the splint has been applied as	

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F 688	Continued From page 13 revealed that Resident # 35 was placed on OT caseload for a left arm splint on 05/17/2018 for 4 weeks that included therapeutic exercises, therapeutic activities and orthotic management. An OT note dated 06/24/2018 at 11:08 AM revealed that the OT educated the Nurse # 5 (Nurse) and Nurse Assistant # 1 (NA) on application of the left arm splint. On 06/25/2018 at 11:14 AM an observation and interview conducted with Resident # 35 revealed that Resident # 35 had no left arm splint on her left hand or arm and Resident # 35 revealed that she did have a splint to wear on her left arm and that she remembered that she always wore it at bedtime. No splint was observed in Resident # 35's room. A nurse progress note dated 06/26/2018 at 10:21 AM revealed that Resident # 35 completed the OT program and would begin the nurse splint program 5 days a week. A review on 06/27/2018 at 4:01 PM of the form titled Splint/ Brace/Prosthesis Rehab Documentation dated 06/01/2018 through 06/27/2018 for Resident # 35 revealed that Resident # 35 had received range of motion (ROM), extension and flexion of the left arm every Monday through Friday and that NA #1 had applied the new left arm splint on the Resident on 06/25/2018 through 06/27/2018. An interview conducted with the Director Nurses (DON) on 06/27/2018 at 4:05 PM revealed that Resident # 35's splint use was documented Monday through Friday in a yellow notebook at the nurse station. The DON revealed that each	F 688	ordered and that documentation is completed accurately. The Functional Maintenance Certified Nursing Assistant will sign behind the residents assigned Certified Nursing Assistant on the splint/brace/prosthetics rehab documentation form located in the Functional Maintenance Plan notebook on each unit signifying that he/she has checked splint application and documentation. 3. The nurse assigned to the resident is responsible to be the third check which completes the triple check process to ensure the splint has been applied as ordered and that documentation is completed accurately. 4. In the absence of the Functional Maintenance Certified Nursing Assistant a designated Administrative Certified Nursing Assistant or the Clinical Services Supervisor will serve as a backup. 5. The Functional Maintenance Certified Nursing Assistant will be responsible to give the Functional Maintenance Plan notebook to the nurse for final review and initialing. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY CITED. The facility has implemented a triple check system to the Functional Maintenance Program. The Staff Development Coordinator will in-service the Certified Nursing Assistants and Nurses by July 26, 2018 on the policy and procedure for Splint training, application and documentation to ensure each splint	

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F 688	Continued From page 14 month a licensed nurse signed the splint forms and that the facility only applied and removed splints during the day Monday through Friday. The DON also revealed that MD orders were not required for splint application as the OT received the splint order from the MD and the OT also scheduled the splint programs unless the MD ordered a different schedule. An interview conducted with the OT on 06/27/2018 at 4:30 PM revealed that the OT had ordered a left arm splint for Resident # 35 on 05/29/2018 and that Resident # 35 was on OT caseload until 06/25/2018 after Nurse # 5 and NA #1 were educated on splint use. The OT revealed that Resident # 35 started a nursing splint program of the left arm 06/25/2018. The OT stated that she had educated Nurse #5 on 06/19/2018 and NA # 1 on 06/21/2018 on a nurse functional maintenance program. The OT provided a form titled Functional Maintenance Program dated 06/25/2018 that included that Resident # 35's current functional status was to provide Passive Range of Motion (PROM) and slow stretch to improve ROM and joint mobility and was wearing left elbow air splint up to 4 hours daily with no signs or symptoms of skin breakdown. The goal was that Resident # 35 would receive PROM and manual stretch to left upper arm to facilitate greater ease with splint application and that Resident # 35 would wear the left arm splint for 3 to 6 hours for contracture management. The program was to be performed 5 days a week and had been signed by Nurse #5 and NA #1 on the dates the OT had given earlier in the interview. The OT revealed that she had only educated the day shift nurse staff that cared for Resident # 35 because the splint program was only when they worked during the week.	F 688	is checked for proper placement and proper documentation and henceforth this training will be incorporated into the New Hire Orientation Program for Certified Nursing Assistants and Nurses. In addition the facility has re-titled the Restorative Certified Nursing Assistant to the title of Functional Maintenance Certified Nursing Assistant. The facility has also updated the Functional Maintenance Plan Form to included places for staff members to sign and a line for the date indicating when the splint will begin being applying. In addition Resident # 35 has been reevaluated and picked by Occupational Therapy. Initial Occupational Therapy evaluation indicated there had been no change in her range of motion or ability to wear her splint. Occupational Therapy will have completed all re-training of care staff no later than July 26th, 2018. The procedure for implementation is as follows: 1. As per facility Medical Director and Rehab Director Splint and brace applications are done Monday through Friday first shift (7am to 3:30pm) only. The Certified Nursing Assistant assigned to the resident is responsible for placement of splint/brace and documentation. 2. The Functional Maintenance Certified Nursing Assistant will be responsible to ensure that the splint has been applied as ordered and that documentation is completed accurately. The Functional Maintenance Certified Nursing Assistant will sign behind the residents Certified	

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F 688	Continued From page 15 On 06/28/2018 at 7:40 AM Resident # 35 was observed eating in the dining room with no left hand or arm splint in place. On 06/28/2018 at 7:40 AM an interview conducted with NA #1 revealed that she planned to put the new left arm splint on Resident # 35 after breakfast and that the left arm splint was worn during the week (Monday through Friday) for about 3 to 6 hours. NA #1 revealed that she had been educated about Resident # 35's left arm splint by the OT and that she had been instructed to apply the left arm splint every Monday thru Friday for 3 to 6 hours a day. NA #1 stated that she had not applied the splint on the left arm of Resident # 35 as she had taught beginning on 06/25/2018 through 06/27/2018 and that she had no reason why the splint had not been used beginning 06/25/2018. On 06/28/2018 at 8:04 AM an interview was conducted with the Assistant Rehab Director (ARD) that revealed that the OT was responsible to train at least 1day shift nurse and 1day shift NA of splint use, would also write the plan of care for the splint program and then it was the nurse staff responsibility to follow the plan of care. The ARD revealed that she would discuss the splint program with the DON because she had not been aware that the facility had ever had a concern about the splint program before. On 06/28/2018 at 11:25 AM an interview with Nurse # 5 revealed that she was not certain that Resident # 35 had the left air splint on for the dates of 06/25/2018 through 06/27/2018 because Nurse #5 stated she had been busy and had not paid attention if the splint had been placed or not.	F 688	Nursing Assistant on the splint/brace/prosthetics rehab documentation form located in the Functional Maintenance Plan notebook on each unit signifying that he/she has checked splint application and documentation. 3. The nurse assigned to the resident is responsible to be the third check which completes the triple check process to ensure the splint has been applied as ordered and that documentation is completed accurately. 4. In the absence of the Functional Maintenance Certified Nursing Assistant a designated Administrative Certified Nursing Assistant or the Clinical Services Supervisor will serve as a backup. 5. The Functional Maintenance Certified Nursing Assistant will be responsible to give the Functional Maintenance Plan notebook to the nurse for final review and initialing. THE MONITORING PROCEDURE TO ENSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE AND THAT THE SPECIFIC DEFICIENCY CITED REMAINS CORRECTED AND/OR IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS: The Director of Nursing or Nurse Manager will be responsible to complete a Quality Assurance Round of the splint application and documentation accuracy on a weekly basis for twelve (12) weeks, then bi-weekly basis for eight (8) weeks, then on a monthly basis. If at any time it is noted that the policy and procedure is not being followed it will be reported to the	

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F 688	Continued From page 16 Nurse #5 revealed that Nurse # 5 had been educated by the OT about the left arm splint and the OT orders for splint application and that she had every confidence that NA #5 would apply the left arm splint. Nurse # 5 revealed that it was the NA's responsibility to report any changes in splint application to a licensed nurse. An interview conducted with the DON on 06/28/2018 at 7:22 PM revealed that the DON expected that all splints be applied as ordered and documented on the plan of care as directed by the rehab therapist and that she expected all nurse staff to review the plan of care or ask other staff if there were any questions or concerns related to splint application.	F 688	Director of Nursing if she is not completing the Quality Assurance check and the Director of Nursing will be responsible to ensure that the retraining is completed. The Director of Nursing will be responsible to review the reports and take necessary steps to include re-training up to include disciplinary action. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION: The Director of Nursing will be responsible for implementing the acceptable plan of correction as follows. The Nurse Manager will conduct an audit on the Splint application and documentation as stated for the Quality Assurance process. The Director of Nursing will review the report prepared by the Nurse Manager and will be responsible to take necessary steps to include retraining up to include disciplinary action. The Quality Assurance forms will be presented to the Quality Assurance Committee on a quarterly basis.	
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 appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/26/18

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F 761	Continued From page 17 §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 observations and staff interviews the facility failed to remove expired medications from one of two medication rooms and one of three medication carts inspected for medication storage. Findings included: 1. Review of the document received from the pharmacy titled "Short Dated Medications 2012" revealed multi-dose insulin glargine injection pens expired 28 days after the pen was opened. An observation was conducted on 6/26/18 at 1:54 PM of the 100 Hall medication room. An observation of the medication storage refrigerator revealed a multi-dose insulin glargine injection pen dated with an open date of 5/21/18. The insulin injection pen had a sticker label on it which	F 761	THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficiency was a result of the facility not following a consistent process of checking the medication carts and refrigerators for expired medications. The facility has collaborated with the pharmacy to obtain a sticker for medications that has a specific place to document the expiration date. We have implemented a process that broadens the scope of the individuals responsible for checking for expired medications. We have also set a schedule for which the carts and refrigerators are to be checked. The Staff Development	

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F 761	Continued From page 18 stated to discard the insulin injection pen 28 days after opening. The insulin injection was stored inside of a container which also had been dated as opened on 5/21/18 and had a sticker label that stated to discard the insulin injection pen 28 days after opening. Nurse #2 who was present during the observation and whose cart the medication was discovered on stated the medication should have been discarded due to the insulin injection pen having been opened more than 28 days ago. An interview was conducted with the Director of Nursing (DON) on 6/28/18 at 7:00 PM. The DON stated her expectation was for expired insulin to be disposed of. 2. An observation was conducted on 6/26/18 at 2:07 PM of cart #3 which was used for the 300 Hall of the facility. An observation discovered a multi-dose insulin lispro injection pen dated with an open date of 5/27/18. Nurse #3 who had been assigned to cart #3 stated she usually disposed of the insulin lispro injection pen on day 30. Nurse #3 contacted the facility's pharmacy and obtained a document titled "Short Dated Medications 2012." Review of the document revealed the multi-dose insulin lispro injection pen expired 28 days after the pen was opened. The nurse stated she was going to dispose of the multi-dose insulin injection pen due to it having been opened more than 28 days ago. An interview was conducted with the Director of Nursing (DON) on 6/28/18 at 7:00 PM. The DON stated her expectation was for expired insulin to be disposed of.	F 761	Coordinator will in-service the nurses by July 26, 2018 concerning the policy and procedure for labeling, dating and destroying medications to include medications that are in single dose administration forms, in the appropriate time frame. In addition this training has been incorporated into the new nurse employee orientation training program. The procedure will be as follows: 1. When a medication (such as eye drops, insulin, inhalers) that have a shelf life that requires an expiration date once opened by the nurse, is sent by the pharmacy it will now contain a sticker with a place for an opening date, an expiration date and the nurses initials. 2. When a medication (such as eye drops, insulin, inhalers) is opened by the nurse it will be his/her responsibility to label the bottle/package/pen with the open date and the expiration date along with their initials. 3. A Medication Reference Guide is placed in the narcotic notebooks on each cart that have specific time frames for usage. Based upon this information the nurse will calculate the number of days in order to list the expiration date of the medication. 4. Each nurse is responsible when administering medications to note if the medication has been labeled with an open date. If it is not labeled the medication will be dated based upon the fill date of the medication on the label. 5. Each nurse is responsible to review the cart during their 8/12 hour shift for expired medications. The nurse will sign	

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F 761	Continued From page 19	F 761	a form at the end of the shift that will be located in the narcotic count book that they have reviewed the cart and expired medications were removed. 6. Expired medications will be removed from each cart and will be placed in the tote to send back to the pharmacy to be destroyed on the next scheduled pick up date. 7. The Nurse on the 11pm-7am shift will be responsible to check the medication rooms to include refrigerated medications on each unit and the stock medications located in Lillian's Way Medication Room on a bi-weekly basis to ensure those medications are labeled and that all medications that are discontinued or are out of date will be placed in the tote to send back to pharmacy to be destroyed on the next scheduled pick up date. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY SITED: The Staff Development Coordinator will in-service the nurses by July 26, 2018 concerning the policy and procedure for labeling, dating and destroying medications to include medications that are in single dose administration forms, in the appropriate time frame. The procedure will be as follows: 1. When a medication (such as eye drops, insulin, inhalers) that have a shelf life that requires an expiration date once opened by the nurse, is sent by the pharmacy it will now contain a sticker with a place for an opening date, an expiration date and the nurses initials.	

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F 761	Continued From page 20	F 761	2. When a medication (such as eye drops, insulin, inhalers) is opened by the nurse it will be his/her responsibility to label the bottle/package/pen with the open date and the expiration date along with their initials. 3. A Medication Reference Guide is placed in the narcotic notebooks on each cart that have specific time frames for usage. Based upon this information the nurse will calculate the number of days in order to list the expiration date of the medication. 4. Each nurse is responsible when administering medications to note if the medication has been labeled with an open date. If it is not labeled the medication will be dated based upon the fill date of the medication on the label. 5. Each nurse is responsible to review the cart during their 8/12 hour shift for expired medications. The nurse will sign a form at the end of the shift that will be located in the narcotic count book that they have reviewed the cart and expired medications were removed. 6. Expired medications will be removed from each cart and will be placed in the tote to send back to the pharmacy to be destroyed on the next scheduled pick up date. 7. The Nurse on the 11pm-7am shift will be responsible to check the medication rooms to include refrigerated medications on each unit and the stock medications located in Lillian's Way Medication Room on a bi-weekly basis to ensure those medications are labeled and that all medications that are discontinued or are	

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F 761	Continued From page 21	F 761	out of date will be placed in the tote to send back to pharmacy to be destroyed on the next scheduled pick up date. THE MONITORING PROCEDURE TO ENSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE AND THAT THE SPECIFIC DEFICIENCY CITED REMAINS CORRECTED AND/OR IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS: The Director of Nursing or Nurse Manager will be responsible to complete a Quality Assurance Round of Medication Carts and Rooms on a weekly basis for eight (8) weeks, then bi-weekly basis for one (1) month, then on a monthly basis. The Medication Carts and Rooms will be monitored to ensure that the Nurses are dating and returning medications as per protocol. If at any time it is noted that the policy and procedure is not being followed it will be reported to the Director of Nursing if she is not completing the Quality Assurance check and the Director of Nursing will be responsible to ensure that the retraining is completed. The Director of Nursing will be responsible to review the reports and take necessary steps to include re-training up to include disciplinary action. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION: The Pharmacy Representative/Pharmacist Consultant comes to the facility on a monthly basis and while here conducts an audit of medication carts and the Medication	

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F 761	Continued From page 22	F 761	Rooms. In their report to the Director of Nursing they will list the deficient practices that were noted. The Director of Nursing will be responsible to review the report and take necessary steps to include re-training up to include disciplinary action. The Quality Assurance forms will be presented to the Quality Assurance committee on a quarterly basis.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		7/26/18

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to accurately document the left elbow air splint for one of one residents (Resident # 35) reviewed for splint documentation. The findings included: Resident # 35 was readmitted to the facility on 06/07/2015 with diagnoses that included vascular dementia, depression, abnormal posture, functional quadriplegia and left elbow contracture. A review of a quarterly Minimum Data Set (MDS) dated 04/19/2018 revealed that Resident # 35 was cognitively impaired and required extensive to total assist with activities of daily living (ADLs) and Resident # 35 was wheel chair bound and had functional limitation in range of motion (ROM) to both upper and lower extremities and had received occupational therapy (OT) services for 150 minutes for 5 days. A review of the care plans for Resident # 35 revealed a care plan initiated on 05/03/2018 that Resident # 35 received restorative therapy for passive range of motion (PROM) to the left upper extremity (LUE) to maintain current range of motion (ROM) and to reduce the risk of contracture development and ease of application of the splint and that Resident # 35 was to wear a left-hand and elbow air splint for up to six hours. The care plan goal was that Resident # 35 would tolerate the PROM and splint program with no signs or symptoms of skin breakdown as evidenced by weekly skin checks through the next review. Interventions included to provide splint program at least 5 days a week for 3 to 6	F 842	THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficiency was a result of the facility not having a check system in place to monitor the accuracy of the documentation in relation to splint application. Resident # 35 has been reevaluated and picked by Occupational Therapy. Initial Occupational Therapy evaluation indicated there had been no change in her range of motion or ability to wear her splint. Occupational Therapy will have completed all re-training of care staff to include proper documentation no later than July 26th, 2018. The facility has developed a triple check system to ensure that the appropriate documentation performed by the Certified Nursing Assistant is done accurately. All documentation will be checked and signed behind for accuracy by the Functional Maintenance Certified Nursing Assistant and the nurse assigned to and responsible for the resident will be responsible for signing behind the Certified Nursing Assistant and Functional Maintenance Certified Nursing Assistant attesting to the accuracy of the documentation. The Staff Development Coordinator will in-service the Certified Nursing Assistants and Nurses by July 26, 2018 on the policy and procedure for proper documentation. Henceforth this	

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F 842	Continued From page 25 hours a day, monitor skin for pressure or redness before and after splint worn, monitor contracture assessment quarterly and to notify therapy services of any changes. Interventions also included to monitor and document Resident #35 of progress in program and to praise Resident# 35 for program participation to give cues as needed and to provide PROM exercises as directed by the OT. An MD order dated 05/29/2018 revealed that a left elbow orthosis had been ordered for Resident # 35. On 06/25/2018 at 11:14 AM an observation and interview conducted with Resident # 35 revealed that Resident # 35 had no left arm air splint on her left hand or arm and Resident # 35 revealed that she did have a splint to wear on her left arm and that she remembered that she always wore it at bedtime. No splint was observed in Resident # 35's room. An interview conducted with the Director Nurses (DON) on 06/27/2018 at 4:05 PM revealed that Resident # 35's left arm air splint use was documented Monday through Friday in a yellow notebook at the nurse station. The DON revealed that each month a licensed nurse signed the splint forms and that the facility only applied and removed splints during the day Monday through Friday. The DON also revealed that MD orders were not required for splint application as the OT received the splint order from the MD and the OT also scheduled the splint programs unless the MD ordered a different schedule. A review of the yellow splint book with the DON on 06/27/2018 at 4:05 PM revealed a form titled	F 842	training will be incorporated into the New Hire Orientation Program for Certified Nursing Assistants and Nurses. The procedure is as follows: 1. The Functional Maintenance Certified Nursing Assistant will be responsible to ensure that documentation is completed accurately. The Functional Maintenance Certified Nursing Assistant will sign behind the residents assigned Certified Nursing Assistant on the splint documentation form located in the Functional Maintenance Plan notebook on each unit signifying that he/she has checked documentation. 2. The resident's assigned nurse is responsible to be the third check which completes the triple check process to ensure that documentation is completed accurately. 3. In the absence of the Functional Maintenance Certified Nursing Assistant a designated Administrative Certified Nursing Assistant, the Clinical Services Supervisor will serve as a backup. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY CITED. Resident # 35 has been reevaluated and picked by Occupational Therapy. Initial Occupational Therapy evaluation indicated there had been no change in her range of motion or ability to wear her splint. Occupational Therapy will have completed all re-training of care staff to include proper documentation no later than July 26th, 2018. The facility has developed a triple check	

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F 842	Continued From page 26 Splint/ Brace/Prosthesis Rehab Documentation dated 06/01/2018 through 06/27/2018 for Resident # 35. Resident # 35 was documented as having worn a left elbow air splint for 3 to 6 hours on 06/25/2018 through 06/27/2018 and was signed by Nurse Assistant #1 (NA). On 06/28/2018 at 7:40 AM Resident # 35 was observed eating in the dining room with no left hand or arm splint in place. On 06/28/2018 at 7:40 AM an interview conducted with NA #1 revealed that she planned to put the new left arm air splint on Resident # 35 after breakfast and that the left arm splint was worn during the week (Monday through Friday) for about 3 to 6 hours. A review of the yellow splint notebook with NA #1 revealed that she had documented (initialed) that she had applied Resident # 35's left arm splint on 06/25/2018 through 06/27/2018. NA #1 revealed that she had not placed the left arm splint on Resident # 35 during those 3 days and NA #1 was not able to explain why she had documented the use of the left arm splint. On 06/28/2018 at 11:25 AM an interview with Nurse # 5 revealed that she was not certain that Resident # 35 had the left air splint on for the dates of 06/25/2018 through 06/27/2018 because Nurse #5 stated she had been busy and had not paid attention if the splint had been placed or not. An interview with the DON on 06/28/2018 at 7:22 PM revealed the DON expected that all nursing staff document correctly and honestly.	F 842	system to ensure that the appropriate documentation performed by the Certified Nursing Assistant done accurately. All documentation will be checked and signed behind for accuracy by the Functional Maintenance Certified Nursing Assistant and the nurse assigned to and responsible for the resident will be responsible for signing behind the Certified Nursing Assistant and Functional Maintenance Certified Nursing Assistant attesting to the accuracy of the documentation. The Staff Development Coordinator will in-service the Certified Nursing Assistants and Nurses by July 26, 2018 on the policy and procedure for proper documentation. Henceforth this training will be incorporated into the New Hire Orientation Program for Certified Nursing Assistants and Nurses. THE MONITORING PROCEDURE TO ENSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE AND THAT THE SPECIFIC DEFICIENCY CITED REMAINS CORRECTED AND/OR IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS: The Director of Nursing or Nurse Manager will be responsible to complete a Quality Assurance Round of the splint application and documentation accuracy on a weekly basis for twelve (12) weeks, then bi-weekly basis for eight (8) weeks, then on a monthly basis. If at any time it is noted that the policy and procedure is not being followed it will be reported to the Director of Nursing if she is not completing the Quality Assurance check and the Director of Nursing will be	

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F 842	Continued From page 27	F 842	responsible to ensure that the retraining is completed. The Director of Nursing will be responsible to review the reports and take necessary steps to include re-training up to include disciplinary action. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION: The Director of Nursing will be responsible for implementing the acceptable plan of correction as follows. The Nurse Manager will conduct an audit on the Splint application and documentation as stated for the Quality Assurance process. The Director of Nursing will review the report prepared by the Nurse Manager and will be responsible to take necessary steps to include retraining up to include disciplinary action. The Quality Assurance forms will be presented to the QA Committee on a quarterly basis.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		7/26/18

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F 880	Continued From page 28 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 29 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow contact precautions for one of one resident reviewed for pressure ulcers (Resident #68). Findings included: A review of the facility policy titled Contact Isolation & Standard Precautions, revealed the following: -Standard precautions will be used in the care of all residents regardless of their diagnosis or presumed infections status. A review of the Contact Precautions posting revealed the following: -Wear gloves when entering room or cubicle, and when touching patient's intact skin surfaces, or articles in close proximity. A review of the medical record revealed Resident #68 was originally admitted to the facility on	F 880	THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficiency were a result of the facility not having a procedure in place to adequately train the treatment nurse. The facility has implemented a system that will more specifically address the policy and procedure during training. The Director of Nursing completed Counseling and Re-education of the treatment nurse on July 4th, 2018. Re-education included reviewing the Alston Brook Clean Dressing Change Policy and review of Wound Source publication on Clean Dressing Techniques, including a “cheat sheet” for dressing changes with clean technique. The Staff Development Coordinator will	

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F 880	Continued From page 30 5/12/18 and was readmitted to the facility on 5/19/18. Review of Resident #68's electronic medical record revealed the resident was on contact precautions for a Urinary Tract Infection (UTI) where the infectious bacteria was documented as Methicillin-Resistant Staphylococcus Aureus (MRSA). Further review revealed the resident had a pressure ulcer to the left heel for which he was receiving dressing changes. Review of the physicians' Medication Administration Record (MAR) revealed the resident received the following antibiotics for the treatment of the UTI: Sulfamethoxazole DS one tablet orally each day from 6/5/18 through 6/6/18, Sulfamethoxazole DS one table twice daily orally from 6/7/18 through 6/12/18, and tetracycline 250 milligram (mg) one tablet twice daily orally from 6/13/16 through 6/19/18. A continuous observation of a dressing change to the residents left foot completed by Nurse #4 for Resident #68 was conducted on 6/27/18 at 10:05 AM. There was signage outside of the Resident #68's room for notification of the room being under Contact Precautions. The notification for Contact Precautions included: Wear gloves when entering room or cubicle, and when touching patient's intact skin surfaces, or articles in close proximity. Resident #68 was resting in bed and was in a contact precautions room. The observation of the dressing change included the following breaches of infection control: -The barehanded nurse proceeded apply the resident's sock, covered the resident's foot with a sheet and comforter, and proceeded to lower the resident's bed from the working level it had been at.	F 880	complete a re-training by July 26th, 2018 with the Monday through Friday Treatment Nurse and the Weekend Treatment Nurse to include the following: 1. Importance of Infection Control in relation to wounds 2. Preparing a clean vs. sterile field 3. Proper cleaning of equipment utilized during treatment. 4. Isolation Precautions in Relation to Wounds A skills check off will be completed by the Staff Development Coordinator with the Treatment Nurses prior to July 25th, 2018. If the Treatment Nurses does not attend the re-training and complete the Skills Check off by the specified date she will not be allowed to work until completed. THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE SPECIFIC DEFICIENCY SITED: The Director of Nursing completed Counseling and Re-education of the treatment nurse on July 4th, 2018. Re-education included reviewing the Alston Brook Clean Dressing Change Policy and review of Wound Source publication on Clean Dressing Techniques, including a “cheat sheet” for dressing changes with clean technique. 1. The Staff Development Coordinator will complete a re-training by July 26th, 2018 with the Monday through Friday Treatment Nurse and the Weekend Treatment Nurse to include the following: 2. Importance of Infection Control in relation to wounds 3. Preparing a clean vs. sterile field	

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F 880	Continued From page 31 -After washing her hands the nurse picked up the bandage scissors and pen from the resident's over the bed table and proceeded to exit the contact precautions room without having had cleaned the bandage scissors or the pen. As the nurse was taking the biohazard bag to the soiled utility room, she placed the bandage scissors and the pen directly on the wound/treatment cart which was located in the hall outside of the resident's room. The nurse then proceeded to go to the soiled utility room to dispose of the biohazard bag and then to the clean utility room where she washed her hands. The nurse then returned to the wound treatment cart and proceeded to clean the bandage scissors and the pen with a disinfectant wipe. An interview was conducted with Nurse #4 on 6/27/18 at 11:12 AM. The nurse stated she did not have three pairs of gloves and after she had removed her gloves after applying the dressing she should have put on another pair of gloves when she applied the resident's sock. The nurse stated she did not see her placing the scissors on her cart as an opportunity for the spread of infection because she used an antiseptic wipe to clean the scissors and the surface of her wound/treatment cart after she had placed the scissors on her cart. An interview was conducted with the Director of Nursing (DON) on 6/27/18 at 3:40 PM. The DON stated the nurse should have used a disinfectant wipe on the scissors before she left the room.	F 880	4. Proper cleaning of equipment utilized during treatment. 5. Isolation Precautions in Relation to Wounds A skills check off will be completed by the Staff Development Coordinator with the Treatment Nurses prior to July 26th, 2018. If the Treatment Nurses does not attend the re-training and complete the Skills Check off by the specified date she will not be allowed to work until completed. THE MONITORING PROCEDURE TO ENSURE THAT THE PLAN OF CORRECTION IS EFFECTIVE AND THAT THE SPECIFIC DEFICIENCY CITED REMAINS CORRECTED AND/OR IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS: 1. Any new Treatment Nurse will be trained by the Staff Development Coordinator on the following during their orientation or prior to assuming the Treatment Role: a. Importance of Infection Control in relation to wounds b. Preparing a clean vs. sterile field c. Proper cleaning of equipment utilized during treatment. d. Isolation Precautions in Relation to Wounds 2. The Director of Nursing or Designee will Monitor treatments to ensure Infection Control procedures are being practiced as follows: a. Monitor two (2) treatments per week for four (4) weeks; then b. Monitor one (1) treatment per week for four (4) weeks; then c. Monitor one (1) treatment monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

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F 880	Continued From page 32	F 880	until resolved by the Quality Assurance Committee. d. The Director of Nursing or Designee will monitor one (1) treatment periodically each month going forward. 3. The Director of Nursing will review the report prepared by the Designee and will be responsible to take necessary steps to include retraining up to include disciplinary action. 4. The Quality Assurance forms will be presented to the Quality Assurance Committee on a quarterly basis. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION: The Director of Nursing will review the report and take necessary steps to include re-training up to include disciplinary action. The Quality Assurance forms will be presented to the Quality Assurance Committee on a quarterly basis.	