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	345520	A. BUILDING _____ B. WING _____	C 08/07/2018

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CURIS AT THOMASVILLE TRANSITIONAL CARE & REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

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F 000	INITIAL COMMENTS An unannounced compliant investigation was conducted 8/5-7/2018. The facility was not in compliance with applicable requirements of 42 C.F.R. Part 483, Health Standard Requirements for Long Term Care Facilities. F580D F684G F732B F880D	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		8/23/18

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

Electronically Signed | 08/30/2018

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F 580	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident guardian and staff interviews, the facility failed to notify a resident ' s guardian for a significant change of status and transfer to the hospital for treatment for 1 of 3 residents reviewed for notifying family (Resident #2). Findings included: The facility policy "Change in resident ' s condition or status" dated August 2011 under the section "Protocol for notifying resident ' s family or sponsor when there is a change in the resident ' s medical condition" was reviewed and it stated, in	F 580	1.Corrective action has been accomplished for the alleged deficient practice in regard to Resident #2, Resident #2 is no longer in the facility. 2.Current facility residents have the potential to be affected by the alleged deficient practice. Director of Nursing conducted 100% audit on 8/8/2018 for the prior 30 days to ensure proper notification was completed on residents that were transferred to the hospital. No negative outcomes.	

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F 580	Continued From page 2 part: ...the nurse will notify the resident ' s family or representative when ... it is necessary to transfer the resident to the hospital." A guardianship form dated 11/29/2016 was reviewed and it was noted Resident #2 was found to be incompetent and a guardian was appointed for him. Resident #2 was admitted to the facility on 2/18/2017, readmitted on 6/18/2018 and expired at the facility on 8/2/2018. Diagnoses for Resident #2 included paraplegia, bilateral above the knee amputee and neurogenic bladder. A review of the social work notes dated 2/13/2018 was reviewed and it revealed documentation related to the legal guardian of the resident, as well as noting the resident was his own responsible party for finances, which were managed through the facility. A review of the nursing notes dated 5/13/2018 written by Nurse #1 revealed Resident #2 was sent to the hospital for evaluation on 5/13/2018 for blood in his urine. The note documented the resident was his own responsible party (RP) and no family notification was done. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/26/2018 assessed the resident to be cognitively intact without behaviors. Resident #2 ' s guardian was interviewed via phone call on 8/6/2018 at 9:38 AM. The guardian reported Resident #2 had been sent to the hospital by the facility on 5/13/2018, and she was not notified until 5/15/2018 by the hospital social	F 580	3.Measures put in place to ensure the alleged deficient practice does not recur include: Director of Nursing initiated in service of all licensed clinical staff on 8/22/2018 on notification of responsible party when a resident is transferred to the hospital. This will also be added to all clinical staff new hire orientation. Director of Nursing/Nurse Manager will audit residents that are transferred to the hospital during Clinical Morning meeting Monday thru Friday for 3 months to ensure that the responsible party was notified. 4.The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consists of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, and Medical Director. 5.The Administrator will be the person responsible for implementing the acceptable plan of correction. 6.Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of thee truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared ad/or executed solely because it is required by the provision of federal and	

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F 580	Continued From page 3 worker/discharge planner. Nurse #1 was interviewed on 8/5/2018 at 7:13 PM and she reported Resident #2 was sent to the hospital on 5/13/2018 because he was not feeling well and he had blood in his urine. She further explained because the resident was alert and oriented, she had not contacted the guardian. Nurse #1 concluded that a guardian did not need to be notified when a resident was listed as their own RP. The Administrator was interviewed on 8/7/2018 at 11:55 AM. He reported that the guardian for Resident #2 had reported this incident to him and because of that incident, nurses were to contact the emergency contact person if a resident had a change and if the resident was their own RP with a guardian, the nurses are to contact the guardian for a change in status of the resident. The Administrator stated it was his expectation the nurses would contact the guardian or emergency contact person for all residents when there was a change in status. The Director of Nursing (DON) was interviewed on 8/7/2018 at 12:00 PM and he stated it was his expectation the nurses notified the emergency contact person or guardian for residents when the resident experienced a change in status.	F 580	state law.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		8/23/18

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F 684	Continued From page 4 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to report a fall for one of three residents reviewed for falls (Resident # 8). Resident #8 experienced a fall when a nursing assistant transferred her from her bed to her wheelchair and the fall was not immediately reported. As a result of this fall Resident #8 experienced pain and a fracture of her distal femoral metaphysis (left thigh bone just above the knee). Findings included: Resident # 8 was admitted to the facility on 05/29/18 with diagnoses that included muscle weakness, macular degeneration, schizophrenia and psychotic disorder. A comprehensive Minimum Data Set (MDS) dated 06/05/18 revealed that Resident # 8 had severely impaired vision, was cognitively intact and required limited assist of one staff for transfers and was non-ambulatory. Resident # 8 was unsteady with surface to surface transfer and was only able to stabilize self with staff assistance. Resident # 8 had no falls during the review period. A review of a fall risk assessment dated 06/05/2018 revealed that Resident # 8 had a risk score of 8 and was a high risk for fall. A fall potential care plan had been initiated.	F 684	1.Corrective action has been accomplished for the alleged deficient practice in regard to Resident #8, resident was sent to hospital on 7/22/2018 for evaluation of fracture. Resident returned with new orders for pain medication; pain medication as per Physician orders. 2.Current facility residents have the potential to be affected by the alleged deficient practice. Nurse Consultant completed 100% audit on 8/8/2018 to ensure that all residents with falls have orders for pain medication and monitoring to ensure reported pain treated in a timely manner. 3.Measures put in place to ensure the alleged deficient practice does not recur include: Director of Nursing initiated an in service of all current staff on 7/22/18 on what constitutes a fall and steps to report falls and suspected falls. This training will also be added to all staff new hire orientation. On 8/22/2018 the Director of Nursing initiated an in service of all licensed staff on reporting pain. This training will also be added to all clinical staff new hire orientation. Director of Nursing will review all falls in Clinical Morning Meeting Monday thru Friday for 3 months to ensure that pain was treated and pain	

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F 684	Continued From page 5 A review of a care area assessment (CAA) dated 06/11/2018 revealed that Resident # 8 required limited to extensive assist with activities of daily living (ADLs). A CAA for Resident # 8 revealed that she was at risk for falls due to blindness and limited mobility. A review of an ADL care plan initiated on 07/18/2018 for Resident # 8 revealed that she would receive strengthening exercises and transfer training in restorative nursing by use of the omnicycle for 15 minutes 3 times a week. A care plan for Resident # 8 revealed that she had an ADL deficit with an intervention to provide limited to extensive assist with transfers. A care plan also revealed a risk for falls and the goal was that Resident # 8 would be free of falls with interventions that included to maintain a safe environment, to keep call light and other items within reach. A facility incident report note dated 07/21/2018 at 6:37 PM revealed that Resident # 8 alerted the nurse that she had pain her left knee and revealed that she fell on her knees that morning. The nurse asked Resident # 8 how she fell, and Resident # 8 replied it had happened that morning when the girl had tried to get her out of bed. The nurse attempted range of motion (ROM) and Resident # 8 responded by yelling and verbalized increased pain. The nurse applied ice to the left knee and notified the MD and the RP. New orders had been received and report given to the next nurse and the Director of Nurses (DON). The facility incident reports revealed that on 07/22/2018 Resident # 8 was alert, wheel chair bound, alert with some confusion. Currently full	F 684	medication was administered per physician order. 4.The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consists of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, and Medical Director. 5.The Administrator will be the person responsible for implementing the acceptable plan of correction. 6.Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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weight bearing status with imbalance without assist of staff. Resident # 8 stated on 07/21/2018 she fell when she was assisted to the wheel chair. Ice was applied to the left knee and Resident # 8 was medicated for pain. Resident # 8 rated her pain at a 6 out of 10. The MD (Physician) and RP (Responsible Party) aware and order an order was received for a muscle relaxer and left leg and knee x ray. The front of left knee was red in color. Resident # 8 to wear gripper socks when out of bed.

A review of a Restorative Care Flow Record dated for July 2018 revealed that Resident # 8 had received on level omnicycle for 15 minutes 3 times a week on 07/11/2018 through 07/13/2018, on 07/16/2018, 07/18/2018 and 07/20/2018 and for 6 minutes on 07/21/2018. Nurse assistant (NA) # 5 reported to the medication aid (MA) # 5 that Resident # 8 had complained of left leg pain and that restorative nursing stopped because of pain complaint by Resident # 8.

Review of a nurse progress note dated 07/21/2018 at 6:37 PM revealed that Resident # 8 alerted nurse # 2 that her left knee hurt. A pain assessment revealed that Resident # 8 revealed that her pain rated a 6 out of 10 on a pain scale during range of motion (ROM) and that Resident # 8 yelled during the hands-on nurse assessment. The nurse notified the physician (MD) and received an order to obtain a left knee x- ray, administer baclofen 5 mg orally (po) every 6 hours as needed (prn) for left knee pain and muscle pain. The resident and the RP were notified of the MD orders.

A nurse progress note dated 07/22/2018 at 6:37 AM revealed that an x ray of the left knee of

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Resident # 8 had been obtained on 07/21/2018 and the x ray report revealed that Resident # 8 had a probable subtle fracture of the supracondylar area of the distal femur, medially.

On 07/22/2018 at 7:34 AM a nurse progress note revealed that Resident # 8 was transferred to the emergency room (ER) as per the MD order and the nurse phoned the RP to give an update. Resident # 8 revealed that at the time of transfer, her pain rated a 10 out of 10 and the vital signs of Resident # 8 were stable at the time of transfer.

An ER MD note dated 07/22/2018 revealed that Resident # 8 arrived in the ER at 9:03 AM after a fall on 07/21/2018 with left knee pain and an x ray of a possible distal femur fracture. The ER performed a left leg and knee x ray that revealed that Resident # 8 had a diagnosis of osteopenia, mild degenerative joint disease and a non-displaced fracture of the distal femoral metaphysis with large joint effusion. A left knee immobilizer was ordered as well as hydrocodone-acetaminophen (Norco) 5- 325 mg (milligrams) per tablet was ordered.

A nurse progress note dated 07/22/2018 at 2:37 PM revealed that Resident # 8 had returned from the ER at 12:40 PM with MD orders for pain medication and a left knee immobilizer. The RP and MD were made aware.

An MD order dated 07/22/2018 at 3:00 PM was to administer enoxaparin sodium (lovenox) 40 mg/ 0.4 ml (milligrams/milliliters) subcutaneously 1 time a day for DVT (deep vein thrombosis) prevention for 2 weeks. Resident # 8 was to follow up with the orthopedic MD as soon as possible. Resident # 8 was to wear the left knee

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immobilizer at all times except when bathing and the nurse was to assess the skin under the immobilizer every shift.

An orthopedic consult dated 07/25/2018 revealed that Resident # 8 had a left femur fracture with minimal displacement and that Resident # 8 was a poor surgical candidate and was to be no weight bearing with a locked extension brace in place at all times with lovenox 40 mg daily for 2 weeks recommended and to return in 3 weeks. The next appointment scheduled for 08/17/2018.

An MD order dated 07/25/2018 was to maintain the left knee immobilizer on the left knee of Resident # 8 locked in extension at all times except for bathing and nurse to assess skin under the left knee immobilizer.

An MD order dated 07/31/2018 was to administer Norco 10/325 mg po every 6 hours as needed, discontinue Tylenol and Norco 5- 325 mg.

A review of the medication administration record (MAR) dated for July 2018 revealed that Resident # 8 received tylenol 650 mg orally (po) every 6 hours as needed for pain, baclofen 5 mg po every 6 hours as needed (prn) knee and or muscular pain had been ordered on 07/21/2018. Resident # 8 also received Norco 5- 325 mg tablet orally every 12 hours as needed for moderate to severe pain. On 07/21/2018 the order was changed to administer norco 10-325mg po every 8 hours prn moderate to severe pain. On 07/25/2018 Resident # 8 received lovenox solution 40mg/0.4 ml subcutaneously 1 time a day for DVT prevention for 2 weeks. A pain assessment revealed that Resident # 8 complained of dull, tender pain at 7 out of 10 on 07/08/2018 and on

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07/21/2018 through 07/31/2018, Resident # 8 complained of a dull tender pain of the left leg that had been rated from a 1 to a 10 out of ten and the pain was relieved by the norco.

A review of the treatment administration record (TAR) dated July 2018 was reviewed and revealed that beginning on 07/22/2018, Resident # 8 had worn a knee immobilizer to the left knee at all times, and the immobilizer was removed for bathing. The nurses assessed the skin under the left knee every shift.

A review of the MAR dated August 2018 revealed that Resident # 8 continued to receive lovenox daily, norco 10-325 mg po every 6 hours as needed for pain and that Resident # 8 rated her pain 6 to 10 at times and the pain was described as sharp or aching and tender and relieved by norco.

The TAR dated August 2018 revealed that Resident # 8 continued to wear the extended left knee immobilizer, locked in extension at all times except for bathing and the nurse checked the skin under the left knee immobilizer every shift.

On 08/06/2018 at 2:41 PM a telephone interview conducted with nurse # 2 revealed that she worked 12 hours on 07/21/2018 and 07/22/2018 (7:00 AM to 7:00 PM). Nurse # 2 revealed that on 07/21/2018 she did not recall seeing Resident # 8 out of bed and that she had went to check the blood sugar of Resident # 8 at about 5: 00 or 5:30 PM, resident # 8 verbalized that her left knee hurt. Nurse # 2 revealed that she tried to reposition Resident # 8 for comfort and that Resident # 8 always complained of pain previously and that Nurse # 2 had given MA # 1

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permission to give Resident # 8 her pain medication if it was time. Resident # 8 had revealed that her pain was rated at 10 of 10. MA # 1 or another staff member that Nurse # 2 could not recall stated that Resident # 8 had a fall earlier on 07/21/2018 when the nurse assistant (NA) # 3 was getting her out of bed. Nurse # 2 recalled that she had not seen Resident # 8 out of bed on 07/21/2018. Nurse # 2 then called the MD, RP and DON. An x ray order was obtained for Resident # 8. The DON told Nurse # 2 to keep her updated of any changes and report results received. Nurse # 2 revealed that on 07/22/2018, when she arrived at work an x ray report was received that Resident # 8 had a fractured femur. Nurse # 2 notified the MD, RP and DON and Resident # 8 was sent to the ER. Nurse # 2 completed an incident / accident report the morning of 07/22/2108.

On 08/06/2018 at 3:55 PM an interview was conducted with MA #1. MA #1 revealed that she had worked on day shift 07/21/2018 and that NA # 3 had called her into the room of Resident # 8 for assistance. MA #1 and NA # 5 entered the room of Resident # 8 and observed Resident # 8 on the floor between her bed and her wheel chair and Resident # 8's feet were bent underneath her. Resident # 8 was alert and denied hitting her head and denied any pain. NA # 3 and MA # 1 lifted Resident # 8 off the floor and placed her in her wheel chair that was held steady by NA # 5. NA # 3 reported that Resident # 8 had not fallen and that she had been lowered down NA # 3's left leg to the floor.MA # 1 revealed that she could not recall what the exact time was, but that it had probably been around 9 or 9:30 AM. MA # 1 revealed that at about noon or so, Resident # 8 was taken to the rehabilitation gym for her

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restorative program. NA # 5 called MA #1 into the rehabilitation gym and reported that Resident # 8 was unable to ride the omnicycle any longer because she had complained of a lot of left leg pain. MA # 1 revealed that Resident # 8 was not due for pain medication at that time. MA #1 revealed that she had not reported the fall to Nurse # 2 because she thought that NA # 3 did. MA # 1 revealed that on 07/22/2018, she was directed to wait in the breakroom until the DON at that time, arrived to get her statement and begin an investigation. MA # 1 reported that the DON had taken a written statement from her, educated her about falls, safety and reporting falls. MA # 1 revealed that she had been suspended for 3 days pending an investigation.

An interview conducted with NA # 5 was conducted on 08/06/2018 at 4:10 PM. NA #5 revealed that she had entered the room of Resident # 8 in the morning of 07/21/2018 with MA #1 when NA # 3 asked for assistance. Resident # 8 was observed on the floor and NA # 5 went to stand behind the wheel chair so that MA # 1 and NA # 3 could lift Resident # 8 into the chair. NA # 5 stated that she stood behind Resident # 8 and had not observed the placement of her legs. NA # 5 revealed that Resident # 8 made no complaints of any pain or discomfort. NA # 5 revealed that she also was the restorative nursing aid and had taken Resident # 8 to the Rehab gym later in the morning for her exercises and that when Resident # 8 was on the omnicycle, she had started to complain of left leg pain after 6 minutes. NA # 5 notified MA # 1 and assisted by a stand pivot transfer, Resident # 8 off the omnicycle and back to her wheel chair. NA # 5 wheeled Resident # 8 back to the unit to sit at the table in the common area. NA # 5 revealed

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that she had not informed Nurse # 2 of the fall earlier in the day because she had thought that NA # 3 or MA # 1 would have reported the fall. NA # 5 revealed that she knew she had been wrong not to report the fall to the nurse. On 07/22/2018 NA # 5 gave a written statement to the DON, received education related to falls and reporting falls by the DON.

On 08/07/2018 at 7:58 AM an interview and observation was conducted with Resident # 8. Resident # 8 was awake, alert lying in bed. Resident # 8 revealed that she did recall a recent fall when she was transferred from her bed to her wheel chair. Resident # 8 reported that she did not really remember the details, but that she had ended up on the floor and did not hit or head or feel any pain at the time. Resident # 8 revealed that she had no left leg pain until later in the day and that she reported her pain to the nurse and did receive pain medication. Resident # 8 reported that she had a lot of pain all over her body for a long time, not just in her leg since she fell. Resident # 8 revealed that she did not walk and that right now she had to wear a leg immobilizer on her left leg all the time. Resident # 8 revealed that she had never had a fall before and that her knees just gave out on her that day and she did not know why.

On 08/07/2018 at 9:24 AM a telephone interview was conducted with the previous DON. The DON reported that she had received a call from Nurse # 2 on 07/21/2018 and was informed that Resident # 8 had a fall during morning care and that the fall had not been reported to Nurse # 2 until later in the evening by Resident # 8. The DON was informed that the MD had ordered an x ray and that the RP had also been informed. The

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DON revealed that on the morning of 07/22/2018, Nurse # 2 had phoned the DON and updated her on the x ray report and that the MD had ordered that Resident # 8 be sent to the ER. The DON was informed that the 3 staff that were present at the time of the fall were waiting for the DON in the breakroom. The DON revealed that she came to the facility, received written statements from the staff, the DON educated the nurse staff about falls and reporting falls immediately.

A telephone interview was conducted with NA # 3 on 08/07/2018 at 9: 53 AM. NA # 3 revealed that on 07/21/2018 she had provided ADL care to Resident # 8 for the first time. NA # 3 reported that she had been informed that Resident # 8 was a 1 staff stand- pivot transfer assist. NA # 3 revealed that she was about to transfer Resident # 8 into the wheel chair from the bed and that Resident # 8's legs became weak and that the NA had Resident # 8 lean against the NA's leg and that Resident # 8 was guided to the floor with her legs bent underneath her and the foot of NA # 3 also underneath Resident # 8. NA # 3 stated that she called her peers to help her and that MA #1 and NA # 3 lifted Resident # 8 into her wheel chair while NA # 5 stood behind the wheel chair. Resident # 8 had not hit her head and did not complain of any pain. NA # 5 revealed that she did not know or consider lowering any resident to the floor was considered a fall, she had never been educated about a fall of that type. NA # 3 revealed that she did not report the fall to Nurse # 2 because she thought that the MA (#1) reported the fall because MA # 1 was responsible for passing medications and NA # 5 thought that MA # 1 was also responsible for documentation and reporting to the nurse for all residents. NA # 3 revealed that on the morning of 07/22/2018, she

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had been informed to wait in the breakroom for the DON to arrive. The DON provided education of types of falls and the responsibility of all staff to report any type of fall to the nurse immediately.

An interview was conducted with the interim DON on 08/07/2018 at 10:00 AM revealed that he had not been in employment at the time that Resident # 8 fell but his expectation was that any fall be immediately reported to the licensed nurse without exception and that the licensed nurse followed the policy and procedure and report all falls to the DON as soon as possible when the MD and RP were notified.

A review of the facility in-service/education record dated 07/22/2018 revealed that all licensed nurses, MAs and NAs signed that they had received education that included that the charge nurse was to be immediately notified of any type of fall and that the resident could not be moved until the nurse completed an assessment and verified that the resident could be moved. The Nurse would conduct an investigation, complete a risk management assessment, assess for injury, notify the MD, RP and put immediate interventions in place.

On 08/07/2018 at 1:13 PM an interview was conducted with the MD of Resident # 8. The MD revealed that she did not feel that a delay in the treatment of the left knee fracture of Resident # 8 made any difference in how the left femur fracture was handled because she was a nonsurgical candidate and the fracture was subtle. The MD revealed that participation in the restorative nursing program on 07/21/2018 did not cause any further injury or impairment for Resident # 8 in any way and that the situation was handled

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F 684	Continued From page 15 immediately and appropriately when this fall was identified, and the delay of any time caused no further injury or impairment. On 08/07/2018 at 1:34 PM an interview was conducted with the facility administrator that revealed the expectation is that all staff report any witnessed or unwitnessed fall immediately to the licensed nurse and this was to be done without exception.	F 684		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		8/23/18

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F 732	Continued From page 16 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post current census and nursing staff data for reviewed posted staffing dated from 08/05/2018 through 08/07/2018. Findings included: On 08/06/2018 at 8:00 AM the posted staffing was dated 08/05/2018 with a facility census of 72. All 3 shifts for that date were completed with licensed nurse and nursing assistant (NA) as well as medication aid (MA) that worked on all three shifts for 08/05/2018. The census was documented as 72 residents though the day. On 08/06/2018 at 9:00 AM the posted staff form was dated 08/06/2018 with a current census of 71 for all 3 shifts (days: 7-3 shift; evenings: 3-11 shift; night: 11-7 shift). The receptionist had stated that she had just placed the updated posted staff form for 08/06/2018 into the plastic holder outside of the receptionist window. The Census was listed as 71 for the entire day. An interview conducted with the nurse staff scheduler on 08/06/2018 at 2:58 PM revealed	F 732	1.Corrective action has been accomplished for the alleged deficient practice in regard to proper posting of Licensed Nurse & Unlicensed Staff. The staff posting was corrected to reflect the current census and staff. 2.Current facility residents have the potential to be affected by the alleged deficient practice. Director of Nursing initiated in service on 8/23/2018 for licensed nursing staff on proper posting of licensed and unlicensed nursing staff. 3.Measures put in place to ensure the alleged deficient practice does not recur include: Director of Nursing initiated in service on 8/23/2018 for all licensed nursing staff on proper posting of licensed and unlicensed nursing staff. The scheduler will be responsible for completing and posting the staffing sheet Monday through Friday. The scheduler will complete the staffing sheets for the weekend by Friday afternoon and the weekend Nurse Manager will post the	

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F 732	Continued From page 17 that the posted staffing form was completed by the receptionist and it was based off of the schedule that the scheduler made. The scheduler revealed that she was not certain if the receptionist changed the nurse staffing hours if the hours changed. The schedule revealed that there was a receptionist on the weekends. On 08/07/2018 at 7:45 AM the posted staffing form displayed was dated for 08/06/2018 with a census of 71 and all three shifts for 08/06/2018 were completed and reflected the same nurse staff numbers as observed at 9:00AM on 08/06/2018 at 9:00 AM. At 8:45 AM on 08/07/2018 the posted staffing reflected a facility census for the entire day of 72. The posted staffing form reflected the number of all nursing staff for all 3 shifts and the census for all 3 shifts for 08/07/2018. An interview conducted with the receptionist on 08/07/2018 at 8:50 AM with the receptionist revealed that she worked part time and there were also two other receptionists and that when the receptionist worked, it was the responsibility of them to update the posted staffing forms for the entire day and that included was the current census number and scheduled nurse staff for each shift. The receptionist reported that each receptionist began work at 8: 00 AM and tried to post the current day census and nurse staffing by 8:45 AM at the latest. The receptionist explained that the census numbers were recorded by the nurse on the night shift and returned to the business office. The receptionist explained that she collected the census sheets from the business office when she clocked in and then went to the back hallway and reviewed the posted	F 732	staffing sheet on Saturday and Sunday. Director of Nursing/Nurse Supervisor will ensure the nursing staffing is posted and updated per policy 5 times a week for 3 months. 4.The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consists of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, and Medical Director. 5.The Administrator will be the person responsible for implementing the acceptable plan of correction. 6.Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is require b y the provision of federal and state law.	

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nurse staff schedule and recorded the staff numbers of RNs, LPNs, medication aids and nurse assistants as posted on the main schedule for each shift. The receptionist revealed that she then completed the posted staff form for all 3 shifts, the entire day by about 8:45 AM and posted the form. The receptionist revealed that she did not update the form at all during the day and that as it was posted in the morning, it remained the same for the entire day. The receptionist revealed that the senior receptionist had educated her on completion of recording the posted staffing form as well as the census.

On 08/07/2018 at 10:00 AM the interim Director of Nurses (DON) was interviewed and revealed that he had only started employment on 08/02/2018 and was not aware of the posted staffing being completed by the receptionist and that his expectation was that a licensed nurse updated the census and accurate nurse staffing each shift and that changes were to be documented as they occurred on each shift. The interim DON revealed that the posted staffing form was to be completed on each shift to reflect exactly what the census was at the beginning if the shift and recorded all nurse staffing and that the posted form was to be updated as any changes happened and reflect exactly what the status of the building was at any given time. The interim DON revealed that the form was definitely not to be completed by the receptionist at the beginning of each day to reflect the facility census and nurse staffing on each shift.

An interview with the facility administrator on 08/07/2018 at 1:43 PM revealed that the posted staffing was expected to show a true and precise picture of the current facility census and nurse

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F 732	Continued From page 19 staff and was to be filled in and changed each shift. The administrator revealed that the posted staffing form needed to reflect the facility's current status and any changes in census and nurse staffing by shift.	F 732		
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. 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;	F 880		8/23/18

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F 880	Continued From page 20 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 record review, observations and resident and staff interviews, the facility failed to handle linen in a manner to prevent contamination as evidenced by soiled linen and	F 880	1.Corrective action has been accomplished for the alleged deficient practice in regard to linen found on the floor. Linen was placed in the soiled utility	

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F 880	Continued From page 21 clothing being placed on the floor of 2 of 2 hallways (100 and 200 hallways). Findings included: A review of the facility ' s laundry and bedding, soiled policy was reviewed and it stated, in part: (a) place contaminated laundry in a bag or container at the location where it is used and (b) place and transport contaminated laundry in bags or containers. A tour of the facility on 8/5/2018 at 5:50 AM revealed a soiled towel on the floor of the 200 hall outside the door to room 204. A bag of clothing was observed on the floor of the 100 hall outside room 107 at 6:00 AM. An observation on 8/5/2018 at 6:40 AM revealed the dirty towel remained on the floor outside of room 204. A resident was observed placing a soiled bed pad on the floor outside of the dirty utility room at 7:53 AM on 8/5/2018. Nursing assistant (NA) #2 was interviewed on 8/5/2018 at 6:10 AM. She reported the resident in room 107 had told her he had dirty clothing to go to the laundry and she had bagged up the dirty laundry and set the bag on the floor and had forgotten it. NA #3 was interviewed on 8/5/2018 at 6:40 AM. The NA reported the towel had been on the floor in front of room 204 since she arrived for her shift at 11:00 PM. The NA further reported she had not picked it up and placed it in a bag because	F 880	room. 2.Current facility residents have the potential to be affected by the alleged deficient practice. Director of Nursing initiated an in service on 8/22/2018 with all CNA's, CMA's, LPN's, RN's,and Department Managers on proper procedure for securing dirty linen and disposing of linen. This training will also be added to all CNA,CMA,LPN,RN, and Department Manager new hire orientation. Licensed nursing staff will continue observations of CNA's work area. 3.Measures put in place to ensure the alleged deficient practice does not recur include: Director of Nursing or Manager on Duty will complete daily infection control rounds on each unit to ensure that dirty linen is properly disposed in the soiled utility rooms for 3 months. 4.The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consists of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, and Medical Director. 5.The Administrator will be the person responsible for implementing the acceptable plan of correction.	

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F 880	Continued From page 22 she did not have gloves. An alert and oriented resident was observed dropping the dirty bed pad on the floor on 8/5/2018 at 7:53 AM. The resident was interviewed and she reported she brought her dirty linen to the utility room door and placed it on the floor and the staff would take the dirty linen into the utility room for her. The Administrator was interviewed on 8/7/2018 at 11:55 AM and he reported it was his expectation that soiled linen was bagged inside the resident ' s room and transported to the dirty utility room immediately. The Director of Nursing (DON) was interviewed on 8/7/2018 at 12:00 PM. The DON reported it was his expectation that staff transported dirty linen in a plastic bag to the utility room and that it was not placed on the floor. The DON further reported that gloves are available to all staff at all times on both hallways.	F 880	6.Preparation and/or execution of this plan of correction does not constitute admission for agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. Th eplan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	