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	345520	A. BUILDING _____ B. WING _____	C 04/23/2019

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

(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 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 4/22/19 to 4/23/19. The facility was not found in compliance with applicable requirements of 42 CFR Part 483, Health Standard Requirements for Long Term Care Facilities. F641 F656 F657 F658 F686 F732	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations, the facility failed to accurately code a Minimum Data Set (MDS) for 1 of 3 residents reviewed for MDS accuracy (Resident #1). Resident # 1 was incorrectly coded in the areas of pain, skin conditions, medications and special treatments, procedures and programs. Findings included: Resident #1 was admitted to the facility on 02/16/2019 with diagnoses that included a lesion of the thoracic spinal cord, muscle weakness, muscle wasting, diabetes mellitus type 2 (DM2), paraplegia and neuromuscular dysfunction of the bladder.	F 641	1. Facility failed to accurately code sections J, M, N and O on resident #1 correctly on the Minimum Date Section (MDS) on the Admission Assessment dated 03/06/19. The facility RN, MDS nurse accurately code sections J, M, N and O on resident #1 on 05/08/2019. 2. Current facility resident had the potential to be affected by the alleged deficient practice. The Director of Nursing will conduct an 100% audit on all Admission assessments from 04/01/19 to 04/30/19 to ensure MDS assessments coded correctly for sections JO3OO, JO600, MO210, M0300, M01040, M1200,	5/18/19

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

Electronically Signed | 05/11/2019

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F 641	Continued From page 1 A review of the medical record of Resident # 1 revealed that she had received prn (as needed) pain medication on 03/03/2019 and the pain was rated as a 10 out of 10 for severity and on 03/04/2019 Resident # 1 rated her pain as 6 out of 10. A wound physician (MD) note dated 03/06/2019 revealed that Resident # 1 had a stage 3 pressure ulcer of the sacrum, trauma wound of the right dorsal foot and an unstageable deep tissue area (DTI) of the left heel. The wound MD recommended that Resident # 1 have the wounds off- loaded, floated heels when in bed, a left heel sponge boot and an air mattress. The wound MD ordered daily treatments to the 3 identified skin areas. A review of the Medication Administration Record (MAR) dated 02/2019 revealed that Resident # 1 received an insulin injection on 02/28/2019 at 8:00 AM and the MAR dated 03/01/2019 through 03/31/2019 revealed that Resident # 1 received scheduled insulin injections every night on 03/01/2019 through 03/06/2019. The TARs (Treatment Administration Records) dated 2/2019 through 03/2019 revealed that Resident # 1 received an antifungal topical antibiotic on 02/28/2019 and 03/01/2019 through 03/04/2019. A nurse note dated 02/27/2019 at 2: 49 AM Resident # 1 reported to the nurse that she felt claustrophobic and short of breath and the nurse applied oxygen at 2 liters via nasal cannula on Resident # 1 and the nurse reported the episode in the MD communication book. On 02/28/2019 an NP (nurse practitioner)	F 641	N0300, and N0410. The Audit will be completed by 05/18/19 by Director of Nursing. 3. Measures put in place to ensure the alleged deficient practice does not recur include (coding accurately according to RAI standards). Director of Nursing in-serviced MDS nurse on accurately coding the Minimum Date Set assessments by 05/08/19. The Director of Nursing will conduct weekly audit x 3 months on admission assessments sections JO3OO, JO600, MO210, M0300, M01040, M1200, N0300, and N0410 to ensure correct coding. 4. The Director of Nursing, ADON and Administrator 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 consist of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, Medical Director	

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F 641	Continued From page 2	F 641		

progress note revealed that Resident # 1 had received oxygen via nasal cannula the previous night.

A review of an admission MDS dated 03/06/2019 revealed that Resident # 1 had no cognitive impairment and required assist with activities of daily living (ADLs). Resident # 1 denied pain in the past 5 days (Section J0300 and J0600). Resident # 1 was at risk to develop pressure ulcers and had been admitted to the facility with a stage 2 pressure ulcer and a surgical wound and received surgical wound care, nutrition and hydration to manage skin problems and pressure ulcer care. Ointments and medications were applied to skin other than her feet (MDS section M0210, M0300, M1040 and M1200) Resident # 1 was coded to receive insulin injections for 6 days and did not receive antibiotics during the review period (MDS section N0350 and N0410). Resident # 1 was not coded to have received oxygen therapy while she had been in the facility (MDS section O0100).

A phone interview was conducted at 6:00 PM on 04/22/2019 with the MDS nurse. The MDS nurse revealed that she mainly worked remotely from home but did come in to the facility at least 1 time a week. The MDS nurse reported that she coded every MDS as accurate as possible with the information in the electronic medical record (EMR) when she completed the MDS.

On 04/23/2019 at 10:35 AM an interview conducted with the facility administrator revealed that the expectation was that MDSs be coded accurately according to the guidance of the MDS RAI (Resident Assessment Instrument) and any coding questions be referred to 1 of the 3

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F 641	Continued From page 3 corporate team members.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews the facility failed to review and revise comprehensive care plans for 3 of 3 reviewed for comprehensive care plan review and revision (Resident # 1 for skin impairment, Resident # 4 for skin impairment	F 657	1. Corrective action has been accomplished for the alleged deficient practice regarding Care Plan Timing and Revision. The facility failed to review and revise comprehensive care plans for 3 of	5/18/19

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F 657	Continued From page 4 and Resident #5 for skin impairment). Findings included: 1.Resident #1 was admitted to the facility on 02/16/2019 with diagnoses that included a lesion of the thoracic spinal cord, muscle weakness, muscle wasting, diabetes mellitus type 2 (DM2), paraplegia and neuromuscular dysfunction of the bladder. A wound physician (MD) note dated 03/06/2019 revealed that Resident # 1 had a stage 3 pressure ulcer of the sacrum, trauma wound of the right dorsal foot and an unstageable deep tissue area (DTI) of the left heel. The wound MD recommended that Resident # 1 have the wounds off- loaded, floated heels when in bed, a left heel sponge boot and an air mattress. The wound MD ordered daily treatments to the 3 identified skin areas. The MD documentation and recommendations were not observed in the comprehensive care plan for Resident # 1. A review of an admission MDS dated 03/06/2019 revealed that Resident # 1 had no cognitive impairment and required assist with activities of daily living (ADLs). Resident # 1 denied pain in the past 5 days. Resident # 1 was at risk to develop pressure ulcers and had been admitted to the facility with a stage 2 pressure ulcer and a surgical wound and received surgical wound care, nutrition and hydration to manage skin problems and pressure ulcer care. Ointments and medications were applied to skin other than her feet. Resident # 1 was coded to receive insulin injections for 6 days and did not receive antibiotics during the review period. Resident # 1 was not coded to have received oxygen therapy	F 657	3 residents. On 05/10/2019 the facility MDS nurse reviewed the comprehensive care plan of residents 1, 4, and 5 affected by the deficient practice. On 05/10/2019 the facility MDS nurse revised comprehensive care plans for residents 1, 4 and 5. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The MDS nurse will ensure that the care plans reflect resident current level of care which includes all treatments which reflect all updates to wound staging, measurements and conditions. On 05/14/2019 the facility Director of Nursing and the RN-MDS nurse will conduct an 100% audit of residents Comprehensive Care Plan to ensure that the care plans are reviewed and revised within the 7 days after completion of the comprehensive assessment according to RAI standards. The facility will notify the Wound Care Physician, family member(s), and/or HIPAA authorized contacts per changes reflected in residents Comprehensive Care Plans. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The facility Director of Nursing will conduct weekly audit x 3 months, then monthly audits for 6 months according to RAI standards. Monitor of completed assessments that been within the 7 days' time compliance according to RAI Standards.	

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F 657	Continued From page 5 while she had been in the facility. A review of comprehensive care plans for Resident # 1 dated as initiated 02/28/2019 and updated 03/11/2019 included in part that Resident #1 was at risk for further skin breakdown related to bowel incontinence, impaired mobility and had a diagnosis of paraplegia. Resident # 1 was admitted with a stage 2 pressure ulcer. Goals included the break in skin integrity would show improvement over the next review period and that Resident # 1's risk for further skin breakdown would be minimized daily through the next review. Interventions included to alert the MD of any significant changes or signs and symptoms of infection, daily skin checks during care, encourage compliance with turn and position to promote pressure relief and to offer diet as ordered and encourage protein intake, perform weekly skin checks and incontinent care. A review of a nurse communication form dated 03/12/2019 included that Resident # 1 was to have unaboots to lower extremities bilaterally that were to be changed every 3 days. Resident # 1 was to have an air mattress to her bed. A review of a wound MD note dated 03/13/2019 revealed that Resident # 1 had a stage 3 pressure ulcer of the sacrum, a trauma wound of the right, dorsal foot, an unstageable deep tissue pressure injury (DTI) of the left heel and unstageable pressure DTI of the right lateral ankle. The wound MD orders and recommendations were not observed in the care plans of Resident #1. A phone interview was conducted 0n 04/22/2019 at 6:00 PM with the MDS nurse. The MDS nurse revealed that the information on the admission	F 657	4. The Director of Nursing and Administrator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 6 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consist of Executive Director, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, Medical Director.	

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F 657	Continued From page 6	F 657		

care plan of Resident # 1 were converted to the comprehensive care plan of Resident # 1 and that she did not update or revise care plans unless the nurse management staff requested her to do such. The MDS nurse revealed that she did review and revise care plans when she completed an MDS. The MDS nurse explained that since she worked remotely she had as best as she was able to recall educate the Director of Nurses (DON) and administrator how to update resident care plans. The MDS nurse also revealed that the DON and administrator were aware that they could call her anytime if she was needed to review or revise care plans between MDSs. The MDS nurse revealed that MD recommendations should be a part of care plan review and revision.

An interview was conducted with the Assistant Director of Nursing (ADON) on 04/22/2019 at 6:37 PM. The ADON revealed that she did not recall any concerns that Resident # 1 had not received her showers. The ADON also revealed that she did not update resident care plans and that she did not know how to do that.

On 04/23/2019 at 9:30 AM an interview was conducted with the Director of Nurses (DON). The DON explained that the current MDS nurse worked remotely and came to the facility about once a week. The DON revealed that her expectation was that resident care plans be updated by the MDS nurse and the interdisciplinary team as needed and that included a review of MD recommendations and include them on the care plans. The DON revealed that the MDS nurse tried to show her last week how to. The DON revealed that the MDS nurse tried to show her last week how to

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F 657	Continued From page 7	F 657		

update care plans in the electronic record, but that the DON could not update the care plans and that the DON did not have a chance to call the MDS nurse to review the steps again.

On 04/23/2019 at 10:35 AM an interview conducted with the facility administrator revealed that the expectation was that care plans be reviewed as needed and include all disciplines and staff to make the care plans accurate to reflect each resident.

2.Resident # 4 was admitted on 02/07/2019 with diagnoses that included Parkinson's disease, muscle wasting, anxiety, depression and hypothyroidism.
A review of the care plans for Resident # 4 was conducted on 04/22/219 and revealed that the care plans for Resident # 4 were initiated on 02/08/2019 and revised most recently on 02/20/19. Resident # 4 had a care plan that read in part was that Resident # 4 was at risk for skin breakdown due to bowel and bladder incontinence, impaired mobility and dependence on staff for care. The goal was that Resident # 4's risk for skin breakdown would be minimized daily and he would be kept warm and dry daily through the next review. Interventions included in part to apply barrier cream as required, perform daily skin checks, encourage frequent position changes, keep skin clean and dry and perform weekly skin checks.

An admission MDS dated 02/15/2019 for Resident # 4 revealed that Resident # 4 had mild cognitive impairment, was at risk for development of a pressure ulcer, but he did not have a pressure ulcer on admission.

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A review of a wound MD note dated 04/03/2019 revealed that Resident # 4 had an unstageable pressure ulcer (due to necrosis) of the sacrum that had been present for greater than 16 days. Treatment orders were written by the MD and recommendations to reposition Resident # 4, off load the wound and obtain an air mattress for Resident # 4.

A quarterly MDS dated 04/04/2019 for Resident # 4 revealed that Resident # 4 had mild cognitive impairment. Resident # 4 required staff assist with ADLs, was always incontinent of bladder and bowel, was at risk to develop a pressure ulcer and had an unstaged pressure ulcer that was not present on admission.

A wound MD note dated 04/10/2019 that the sacral pressure ulcer of Resident # 4 was now a stage 3 pressure ulcer that measured 4.1 cm x 2.1 cm x 0.3 cm with moderate serous drainage, 30 % granulation tissue with no change. Treatment included weekly alginate calcium 1 time per week, apply a dry protective dressing daily and apply skin prep daily for 14 days.

On 04/22/1019 an observation of Resident # 4 at 4:00PM revealed Resident # 4 in bed on an air mattress.

On 04/22/2019 at 4:21 PM an interview was conducted with the Unit Manager (UM) of the 100-hall revealed that she had no participation in the care plan process such as reviewing them or revising them.

A phone interview was conducted 0n 04/22/2019 at 6:00 PM with the MDS nurse. The MDS nurse revealed that the information on the admission

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F 657	Continued From page 9	F 657		

care plan of Resident # 1 were converted to the comprehensive care plan of Resident # 1 and that she did not update or revise care plans unless the nurse management staff requested her to do such. The MDS nurse revealed that she did review and revise care plans when she completed an MDS. The MDS nurse explained that since she worked remotely she had as best as she was able to recall educate the Director of Nurses (DON) and administrator how to update resident care plans. The MDS nurse also revealed that the DON and administrator were aware that they could call her anytime if she was needed to review or revise care plans between MDSs. The MDS nurse revealed that MD recommendations should be a part of care plan review and revision.

On 04/23/2019 at 9:30 AM an interview was conducted with the Director of Nurses (DON). The DON explained that the current MDS nurse worked remotely and came to the facility about once a week. The Don revealed that her expectation was that resident care plans be updated by the MDS nurse and the interdisciplinary team as needed and that this included a review of MD recommendations and include them on the care plans. The DON revealed that the MDS nurse tried to show her last week how to update care plans in the electronic record, but that the DON could not update the care plans and that the DON did not have a chance to call the MDS nurse to review the steps again.

On 04/23/2019 at 10:35 AM an interview conducted with the facility administrator revealed that the expectation was that care plans be reviewed as needed and include all disciplines

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and staff to make the care plans accurate to reflect each resident.

3. Resident #5 was admitted to the facility on 3/26/19 with diagnoses of failure to thrive, diabetes, and severe malnutrition.
A review of the most recent Minimum Data Assessment, an admission assessment, dated 4/2/19 revealed Resident #5 was moderately cognitively impaired, and she required extensive assistance with turning in bed, transfers to and from the bed, and toileting; had occasional, moderate pain. The assessment further revealed she had a stage one pressure ulcer.

A review of Resident #5's Care Plan initiated 3/27/19 and revised on 4/8/19 revealed she was admitted with a stage 1 pressure ulcer to her left heel. The interventions included weekly skin observation and treatment as ordered.

A review of the Wound Evaluation and Management Summary by the Wound Physician dated 4/10/19 revealed Resident #5 had an Unstageable Deep Tissue Injury to her right heel that measured 4 centimeters length by 6.1 centimeters width. The report also revealed Resident #5 had an Unstageable Deep Tissue Injury to her left heel that measured 0.7 centimeters length by 1.2 centimeters width.

The Wound Evaluation and Management Summary by the Wound Physician dated 4/17/19 indicated Resident #5 had an Unstageable Deep Tissue Injury to the right heel that measured 4 centimeters length by 5.1 centimeters width. The report further revealed Resident #5 had an

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F 657	Continued From page 11 Unstageable Deep Tissue Injury of the left heel that measured 2.6 centimeters length by 2.5 centimeters width. On 4/22/19 at 3:05 pm, during an observation of Resident #5's right heel wound dressing change Nurse #1 stated the right heel wound was a deep tissue injury. During an interview on 4/22/19 at 4:22 pm with Nurse #1 she stated Resident #5's right heel was a possible deep tissue injury on admission and was unstageable. An interview with the Wound Physician on 4/22/19 at 6:20 pm revealed he was not notified of Resident #5's pressure ulcers on her heels until he saw her on 4/10/19. He stated both heels were deep tissue injuries which would make them unstageable. An interview with the Director of Nursing (DON) on 4/23/19 at 9:57 am revealed Resident #5 was seen by the Wound Physician on 4/10/19. She stated the Wound Physician's Wound Evaluation and Management Summary on 4/10/19 stated Resident #5 had Deep Tissue Injuries to both heels and the MDS Coordinator should have updated Resident #5's care plan. During an interview with the Administrator on 4/23/19 at 10:15 am, he stated his expected care plans to be revised with changes in the resident's condition.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		5/18/19

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F 658	Continued From page 12 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, and observation the facility failed to provide pressure ulcer treatment for 1 of 3 residents (Resident #5) reviewed for pressure ulcer care and provide fingerstick glucose monitoring at bedtime as ordered by the physician for 1 of 1 resident (Resident #3) observed for diabetes management. Findings included: 1. Resident #5 was admitted to the facility on 3/26/19 with diagnoses of failure to thrive, diabetes, and severe malnutrition. Her most recent Minimum Data Assessment, an admission assessment, dated 4/2/19 revealed she was moderately cognitively impaired, and she required extensive assistance with turning in bed, transfers to and from the bed, and toileting. The assessment further revealed she had a stage one pressure ulcer. The Treatment Administration Record for 3/2019 revealed Resident #5 did not receive any treatments to her right heel. A review of the Nurse's Admission Note dated 3/27/19 at 1:20 PM by Nurse #2 indicated Resident #5 was admitted on 3/26/19 at 10:30 AM. The note further indicated Resident #5 had a pressure ulcer to her right heel. The Admission Note did not indicate the stage or size of the ulcer.	F 658	1. Corrective action has been accomplished for the alleged deficient practice in regarding resident #5 and resident #3. Resident #5 wound treatment was initiated on 4/11/19. On 04/22/2019 the nurse was identified and in-serviced per the proper application of Point Click Care to ensure blood sugars documentation is timely/accurately and electronically integrated onto the residents' Medication Administration Records (M.A.R.) Resident #3's order for blood sugar check was corrected on 04/22/2019. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing will complete 100% skin assessments by 05/18/2019 on all residents to ensure residents with wounds have wound treatment orders with proper documentation ensuring no other residents were affected. The Director of Nursing completed 100% audit on 4/24/19 on all residents with orders of blood sugar checks to ensure orders are inputted correctly. No other residents were affected. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The facility Director of Nursing	

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F 658	Continued From page 13 A Nurse's Note dated 3/27/19 at 7:51 PM by nurse #2 revealed the resident had a pressure ulcer to her right heel. The note did not reveal the stage or measurements of the right heel pressure ulcer. The Treatment Administration Record for 4/2019 revealed Resident #5 received treatments of "apply betadine to right heel deep tissue injury topically every evening shift for deep tissue injury ". The Treatment Administration Record also revealed Resident #5 began the same treatment to the left heel for a deep tissue injury. Both treatments were ordered on 4/10/19 began on 4/11/19. A Weekly Pressure Ulcer Report completed on 4/3/19 at 3:48 PM by Nurse #1 indicated Resident #5 had a possible deep tissue injury to her right heel and a note was placed in the Wound Physician's book to evaluate the wound. A review of the report revealed no staging or measurements. A review of the Wound Evaluation and Management Summary by the Wound Physician dated 4/10/19 revealed Resident #5 had an Unstageable Deep Tissue Injury to her right heel that measured 4 centimeters length by 6.1 centimeters width. The report also revealed Resident #5 had an Unstageable Deep Tissue Injury to her left heel that measured 0.7 centimeters length by 1.2 centimeters width. A review of the Physician's Orders revealed Resident #5 had an order dated 4/11/19 for Betadine Swab apply to right and left heel Deep Tissue Injury (DTI) every evening and cover with a dry dressing.	F 658	will initiate in service education on 05/16/2019 for all licensed nurses on wound treatments and proper documentation. All new hire nurses will be educated during orientation. The Director of Nursing/Assistant Director of Nursing/Unit Manager will assess all new admission/readmissions with skin assessments to ensure proper treatment and documentation is correct. The facility Director of Nursing will initiate in service education on 05/16/2019 for all licensed nurses on correct order entry. All new hire nurses will be educated during orientation. The Director of Nursing/Assisted Director of Nursing/Unit Manger will review all new orders 5 times a week for 3 months to ensure blood sugar check orders are correctly entered. 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.	

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The Wound Evaluation and Management Summary by the Wound Physician dated 4/17/19 indicated Resident #5 had an Unstageable Deep Tissue Injury to the right heel that measured 4 centimeters length by 5.1 centimeters width. The report further revealed Resident #5 had an Unstageable Deep Tissue Injury of the left heel that measured 2.6 centimeters length by 2.5 centimeters width.

On 4/22/19 at 3:05 pm during an observation of Resident #5's right heel wound dressing change Nurse #1 stated the right heel wound was a deep tissue injury and had been present on admission.

During an interview on 4/22/19 at 4:22 pm with Nurse #1 she stated Resident #5's right heel was a possible deep tissue injury on admission and was unstageable. Nurse #1 also stated Resident #5 had not been seen by the Wound Physician on 3/27/19 or 4/3/19 when he visited the facility. She stated the Wound Physician measures and stages all wounds when he visits the facility once a week and she uses his measurements and staging in her notes. Nurse #1 stated she did not know how the weekly measurements and staging would be done if the Wound Physician does not visit as scheduled.

An interview with the Director of Nursing (DON) on 4/23/19 at 9:57 am revealed Resident #5 had the right heal pressure ulcer that was not staged by the nursing staff or the wound physician on admission. She stated on 4/3/19 it was noted to be a deep tissue injury on a Nurse #1's Weekly Pressure Ulcer Report. The DON stated the wound should have been staged and measured on admission, and orders for treatment obtained. The DON stated Nurse #1 should have notified

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her the Wound Physician did not assess Resident #5's wounds on his visit on 3/27/19 and 4/3/19. She stated she would have ensured the Resident's wound was assessed when she was admitted.

2. Resident #3 admitted to the facility on 3/22/19 and discharged on 4/15/19. His primary diagnoses were diabetes, Parkinson's disease, and chronic kidney disease. His most recent comprehensive Minimum Data Set (MDS) Assessment dated 3/29/19, an admission assessment, revealed he was cognitively intact and required extensive assistance with all activities of daily living. The assessment further indicated Resident #3 received insulin throughout the assessment period for diabetes.

A review of Resident #3's physician orders revealed an order dated 3/25/19 for Fingerstick Blood Glucose Checks before meals and at bedtime.

The Medication Administration Record for 3/2019 for Resident #3 indicated he received Fingerstick Blood Glucose Checks before meals beginning 3/23/19. No Fingerstick Blood Glucose Checks were recorded for bedtime (10:00 PM).

The Medication Administration Record for 4/2019 for Resident #3 revealed he received Fingerstick Blood Glucose Checks before meals until 4/15/19, but the ordered Fingerstick Blood Glucose Checks at bedtime (10:00 PM) were not recorded.

A Care Plan initiated 3/22/19 indicated Resident #3 had Diabetes. The Care Plan goal was for the resident to have no complications related to his

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F 658	Continued From page 16 diabetes. The interventions listed were fingerstick blood glucose checks as ordered, administer medications as ordered, obtain and review labs work as ordered, observe for compliance with diet, and to monitor for signs and symptoms of hypoglycemia. During an interview with Nurse #4 on 4/22/19 at 3:44 PM she indicated she had put Resident #3's Fingerstick Blood Glucose Checks in the computer when the Physician ordered them. She stated she must have missed putting in the Fingerstick Blood Glucose Check for bedtime and it did not appear on Medication Administration Record. She stated she just missed checking the bedtime (10:00 PM) when she put the order in the electronic system. An interview with the Director of Nursing (DON) on 4/23/19 at 9:47 am pm revealed Resident #3 did not have his Fingerstick Glucose Checks for bedtime (10:00 PM) recorded while he was at the facility. The DON stated Resident #3 did have an order for Fingerstick Glucose Checks before meals and at bedtime. She also stated Nurse #4 had put the order for the Fingerstick Glucose Checks in the computer incorrectly and had left off the bedtime check. The DON further indicated she expected the Nurses to enter all orders into the computer system correctly and the orders should be checked every morning by Nursing Management.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		5/18/19

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F 686	Continued From page 17 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, interviews and observations the facility failed to prevent the development of new pressure ulcers and to prevent worsening of pressure ulcer status for 3 of 3 residents reviewed for pressure ulcers (Resident # 1, Resident #4 and Resident # 5). Findings included: 1.Resident #1 was admitted to the facility on 02/16/2019 with diagnoses that included a lesion of the thoracic spinal cord, muscle weakness, muscle wasting, diabetes mellitus type 2 (DM2), paraplegia and neuromuscular dysfunction of the bladder. Resident # 1 was discharged from the facility 03/02/2019. A review of a discharge summary from the hospital for Resident # 1 dated 02/26/2019 included that Resident # 1 was discharged to the facility with a stage 2 pressure ulcer of the sacrum and the facility was to continue to apply barrier cream to the wound and apply aquacel or mepilex over the wound. A review of a form titled Braden Data Tool for	F 686	1. Corrective action has been accomplished for the alleged deficient practice regarding failed to Prevent/Heal Pressure Ulcer for resident #1, resident # 4 and resident #5. Residents # 1 and # 4 were discharged from the facility prior to survey. Resident# 5 bilateral heels were referred on 04/10/2019 and she was seen by the facility Wound Physician, on 4/11/19 which the proper treatment was implemented to promote wound healing. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The facility Director of Nursing implemented immediately rounding with Unit Manager and Assistant Director of Nursing on all Re-Admission /Admission assessing skin for issues and initiate order/treatments to prevent further deficient practice regarding fail to prevent skin problems on 04/23/19. On 04/25 thru 04/30/2019 the facility Director of Nursing Services performed 100% residents skin assessments on Harmony wing for those having the potential effect of the alleged	

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Resident # 1 dated 02/26/2019 at 2:40 PM included in part that Resident # 1 was a mild risk for skin breakdown and had sensory impairment. Resident # 1 had occasionally moist skin, limited mobility and was served 4 servings of protein every day (QD).

A review of a form titled "Admission Plan of Care" dated 02/26/2019 at 3:33 PM revealed in part that Resident # 1 had blanchable redness of the left gluteal fold, barrier cream was utilized and the blanchable measured 1 to 2 centimeters (cm) in length and width and had 0.5 cm depth. The wound physician (MD) would be contacted.

A nurse note dated 02/27/2019 at 10:57 PM revealed that the stage 2 pressure ulcer on the sacrum of Resident # 1 was cleansed with normal saline solution (NSS) covered with aquacel then applied a dry dressing.

A review of the medical record for Resident # 1 revealed a nurse note on 03/03/2019 at 5:34 PM revealed in part that Resident # 1 had no edema (swelling).

A review of an admission Minimum Data Set (MDS) dated 03/06/2019 revealed that Resident #1 was cognitively intact, required extensive assist with bed mobility, toileting and required set up for meals and Resident # 1 required total assist with transfers. Resident # 1 had an indwelling urinary catheter and was always incontinent of bowels. Resident # 1 was coded as at risk to develop a pressure ulcer and was admitted with a stage 2 pressure ulcer. The MDS was coded that Resident # 1received pressure ulcer care, ointment or medication were applied to Resident # 1 during the review period and

deficient practice. On 04/29 thru 05/14/2019 the facility Assistant Director of Nursing and licensed nursing staff completed an 100% residents skin assessment on Transitional wing for those having the potential effect of the alleged deficient practice.

3. Measures put in place to ensure the alleged deficient practice does not recur: The Director of Nursing/Assistant Director of Nursing/Unit Manager initiated in-service on 05/16/2019 on all License nursing staff and agency nurses on skin assessment procedures which includes staging and measurements upon Admission/Re-Admission and weekly skin assessments of residents in the facility. The Director of Nursing/Assistant Director of Nursing/Unit Manager will assess all residents upon admission and readmission to the facility to identify any/all skin issues and initiate orders/treatments and to ensure measurements and staging to promote/ensure skin healing. The Director of Nursing/Assistant Director of Nursing will perform residents skin assessment which will include measurements and staging in absence of Wound Care Physician.

4. The Director of Nursing, Assistant Director of Nursing, and Administrator will analyze/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

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F 686	Continued From page 19 Resident # 1 received hydration and nutrition to manage skin integrity as well as surgical wound care. A review of the Care Area Assessments (CAAs) for Resident #1 revealed in part that Resident #1 was incontinent of bowel, required extensive assist with bed mobility and was at risk to develop pressure ulcers and was admitted with a stage 2 pressure ulcer of the sacrum and a surgical wound of her back. A wound MD note dated 03/06/2019 revealed in part that Resident # 1 had multiple wounds and mild edema. Wounds included a stage 3 pressure ulcer of the sacrum that measured 5.5 cm by 1 cm by 0.3 cm with moderate serous drainage and 20 % necrotic tissue, 30 % slough tissue and 50% granulation tissue. The wound MD debrided the sacral wound and ordered an alginate calcium dressing covered with a dry protective dressing daily x 14 days ad house barrier cream to be applied three times (TID) x 14 days. Resident # 1 also had a right, dorsal foot trauma wound that measured 2.3 cm x 1.2 cm with no depth. The right, dorsal foot had light serous drainage and 100% granulation tissue. Treatment was to apply xeroform sterile gauze daily (QD) and cover with a dry dressing x 14 days. Resident # 1 had an unstaged DTI of the left heel that measured 1.1 cm x 1.8 cm with no depth. The MD ordered to apply betadine QD x 14 days. The wound MD reported to reposition Resident # 1 per policy, off load wounds, float her heels in bed and apply a sponge boot. The wound MD observed 3 wounds. A weekly nurse skin observation (late entry) note dated 03/09/2019 at 12:00 PM revealed that Resident # 1 had a sacrum area that was treated,	F 686	adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consist of Administrator, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, Medical Director	

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a right heel area and left heel area and an area on the lower front of the right leg with treatments in place and no new areas were observed.

A nurse note dated 03/09/2019 at 5:43 PM revealed that Resident # 1 had a dry dressing in place to the left lateral ankle area was covered with a dry dressing.

On 03/10/2019 at 7:03 PM a nurse note included that treatments continued as directed and booties were applied to both feet of Resident # 1.

Care plans updated 03/11/2019 for Resident #1 included that Resident #1 was at risk for further skin breakdown related to bowel incontinence and impaired mobility (paraplegia). Resident # 1 was admitted to the facility with a stage 2 pressure ulcer. Goals included that Resident # 1would would have improved skin integrity through the next review and further skin breakdown would be minimized through the next review. Interventions included in part to alert the physician (MD) of significant changes or signs / symptoms of infection, provide daily skin checks and report changes, encourage turning and positioning to promote pressure relief, provide diet as ordered, perform weekly skin checks and incontinent care.

A review of 3 nurse communication forms dated 03/12/2019 revealed the facility MD requested the wound MD to see Resident # 1, give Lasix 40 milligrams (mgs) orally (po) daily for edema, apply unaboots to both lower extremities and change them every 3 days. The MD also ordered an air mattress for Resident # 1's wounds.
A wound MD note dated 03/13/2019 revealed in part that Resident # 1 had multiple wounds that

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included a stage 3 pressure ulcer of the sacrum that measured 6 cm x 5.2 cm x 0.3 cm with moderate serous drainage, 20 % necrotic tissue, 30 % slough and 50 % granulation tissue. The wound MD reported the wound deteriorated. The sacral wound was debrided, treatments were reordered x 14 more days and the sacral wound had deteriorated. The trauma wound of the right, dorsal foot measured 1.7 cm x 1.4 cm with no depth, light serous drainage and 100% granulation tissue and improved. The DTI of the left heel of Resident # 1 had no change and measured 2cm x 1 cm x no depth and was a blood-filled blister. Wound # 4 was a DTI pressure ulcer of the right, lateral ankle that measured 3 cm x 3.5 cm x no depth and was a blood-filled blister. Wound care orders were written to continue for 14 to 30 more days.

A review of a weekly pressure ulcer report (late entry) dated 03/13/2019 at 4:30 PM included that Resident # 1 had a left heel pressure ulcer that measured 2 cm in length, 1.0 cm in width and no depth. The left heel pressure ulcer was unstaged and betadine was applied daily, covered with a dry protective and wrapped with gauze.

On 03/13/2019 at 11:44 PM a review of a weekly pressure ulcer report revealed that Resident # 1 had an unstaged pressure ulcer of the right outer ankle (initial observation date was 03/11/2019). The right outer ankle was a blood-filled blister, treated with betadine covered with a dry protective dressing a sponge boot was applied and the heels of Resident # 1 were floated in bed.

An MD note dated 03/14/2019 revealed that Resident # 1 had trace swelling of the legs and was followed by the wound MD.

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A nurse note on 03/15/2019 at 2:00 PM included that xeroform petrolat gauze 1 inch x 8 inches was applied to the right dorsal foot of Resident #1 then apply a dry protective dressing every day until healed.

A weekly pressure ulcer report (late entry) dated 03/16/2019 at 12:00 PM revealed that Resident # 1 had a stage 3 pressure ulcer that measured 6 cm in length, 5.2 cm wide and had a depth of 0.3 cm that was first observed 03/06/2019. The treatment was to apply Santyl with calcium alginate daily cover with a dry protective dressing and apply house barrier cream three times (TID)to the peri wound (tissue around the wound).

A nurse note dated 03/18/2019 at 12:01 AM revealed in part that the wound MD saw Resident # 1 on 03/13/2019 and the unstaged deep tissue injury (DTI) of the right lateral ankle measured 3 cm in length by 3.5 cm wide with no depth was a blister. Resident # 1 had a stage 3 pressure wound, the right dorsal foot wound measured 1.7 cm in length by 1.4 cm wide with no depth. The left heel DTI (blood filled blister) measured 2 cm long by 1 cm wide with no depth. Resident # 1 was admitted with lower extremity edema. Resident # 1 preferred to be on her back in bed.

An interview was conducted with the Assistant Director of Nursing (ADON) on 04/23/2019 at 8:21 AM revealed that the ADON recalled that Resident # 1 was admitted to the facility with a stage 3 pressure ulcer of the sacrum and that after admission, Resident # 1 developed a blister on her right ankle and her left heel. The ADON revealed that Resident # 1 required 2 staff to reposition in bed and Resident # 1 repositioned

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self on to her back. The ADON revealed that she did weekly wound rounds with the wound MD on the 200 hall.

On 04/23/2019 at 9:30 AM the DON was interviewed and revealed that residents needed to reposition at least every 2- 3 hours and the MDS (Minimum Data Nurse) coded section M of the MDS related to skin conditions and the MDS nurse was expected to review MD recommendations and care plan them.

2.Resident # 4 was admitted on 02/07/2019 with diagnoses that included Parkinson's disease, muscle wasting, anxiety, depression and hypothyroidism.

A review of an admission assessment completed by the Director of Nursing (DON) on 02/02/2019 included that Resident # 4 had a wheel chair cushion and a standard facility bed mattress. Resident # 4 also had edema of the extremities.

A Braden risk scale of Resident # 4 dated 02/07/2019 revealed that Resident # 4 was a moderate risk for pressure ulcer development and he required maximum assist with frequent repositioning.
An MD note dated 02/12/2019 revealed in part that Resident # 4 had no reported skin rashes or skin breakdown.
On 02/20/2019 at 10:29 PM a review of a nurse note included in part that Resident # 4 had open areas to his bilateral buttocks.

A review of a care plan initiated on 02/20/2019 reveled that Resident # 4 was at risk for skin breakdown due to incontinence and dependence for care. The care plan goal read in part that

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Resident # 4's risk of skin breakdown would be minimized daily through the next review. Interventions included to apply barrier cream as required, perform daily skin checks and report any changes, encourage / assist with frequent position changes. Provide incontinence care every 2 - 3 hours, perform weekly skin checks.

An MD note dated 02/21/2019 included that staff reported that Resident # 4 had 2 open areas on the bilateral buttocks.

On 03/20/2019 at 7:00 AM a weekly skin observation note revealed that Resident # 4 had an area on his sacrum that worsened a treatment was in place and the wound physician (MD) was notified.

An MD note dated 03/21/2019 was reviewed and revealed that Resident # 4 denied pain of the sacral area and currently had duoderm treatment on the left buttock decubitus and the duoderm was to be continued and changed every 3 days.

A weekly nurse skin observation form dated 03/27/2019 at 7:00 AM revealed that on observation, Resident # 4 had upstaged necrosis of the sacrum and the physician (MD) saw the resident on 03/27/2019 and discontinued the hydrocolloid treatment and changed the sacral treatment order to a calcium alginate dressing daily. The sacral pressure ulcer and left buttock had worsened in condition and the wound MD followed Resident # 4 at that time.

A review of a wound care MD note dated 03/27/2019 revealed that Resident # 4 had an unstageable (due to necrosis) pressure wound of the sacrum. That measured 4.5 cm long by 3.5

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cm wide and a depth of 0.3 cm with moderate serous drainage. The wound MD surgically debrided the sacral wound and ordered an alginate calcium dressing to the sacrum, cover with a dry dressing 1-time weekly x 14 days. House barrier cream to be applied to Resident # 4 every day. Resident # 4 was to be repositioned per protocol and to off load the wound.

An evaluation summary of a weekly pressure ulcer report dated 03/28/2019 at 11:34 AM revealed that the sacral pressure ulcer (unstageable) measured 4.5 cm in length by 3.5 cm wide and had a depth of 0.3 cm. A new order for calcium alginate dressing changed daily, off - loading and zinc oxide applied to the peri area every shift.

A review of a wound MD report dated 04/03/2019 revealed that Resident # 4 had an unstageable pressure ulcer of the sacrum that measured 4.3 cm by 2 cm wide x 0.3 cm deep with moderate serous drainage and 20% slough tissue, 20 % granulation tissue and had improved. The wound MD provided surgical debridement and ordered the same treatments to continue x 14 days and to provide an air mattress.

A review of a quarterly MDS for Resident # 4 dated 04/04/2019 revealed that Resident # 4 had mild cognitive impairment, required total assist for bed mobility, toileting and to eat. Resident # 4 did not transfer. Resident # 4 was always incontinent of bladder and bowel, was at risk to develop a pressure ulcer and had developed 1 unstaged pressure ulcer that was not present on admission. Resident # 4 was on a hydration and nutrition program to manage skin and received pressure ulcer care and an ointment or

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medication was applied to impaired skin.

A wound MD note dated 04/10/2019 that the sacral pressure ulcer of Resident # 4 was now a stage 3 pressure ulcer that measured 4.1 cm x 2.1 cm x 0.3 cm with moderate serous drainage, 30 % granulation tissue with no change. Treatment included weekly alginate calcium 1 time per week, apply a dry protective dressing daily and apply skin prep daily for 14 days.

A weekly pressure ulcer report summary dated 04/11/2019 revealed that Resident # 4 measured 4.1 cm in length by 2.1 cm wide and a had a depth of 0.3 cm. The nurses were to continue daily calcium alginate treatment to the sacrum daily and apply skin prep to the peri wound daily.

On 04/17/2019 a wound MD note for Resident # 4 revealed in part the stage 3 pressure ulcer measured 4.4 cm x 4.2 cm x 0.3 cm. Treatment orders included to apply hydrofiber with silver and skin prep and a dry protective dressing daily x 14 days.

A review of a weekly pressure ulcer report dated 04/18/2019 revealed that Resident # 4's sacral pressure ulcer (stage 3) was 4.4 cm in length by 4.2 cm wide and had a depth of 0.3 cm.

On 04/22/2019 at 4:03 PM Resident # 4 gave verbal permission to observe wound care. Resident # 4 was on an air mattress in bed. No concerns were identified during wound care.

On 04/22/2019 at 4:21 PM an interview with the Unit Manager (UM) of the 100-hall revealed that the wound care MD came to the facility weekly and that she did make wound care rounds with

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F 686	Continued From page 27 the MD. On 04/23/2019 at 9:30 AM the DON was interviewed and revealed that residents needed to reposition at least every 2- 3 hours and the MDS (Minimum Data Nurse) coded section M of the MDS related to skin conditions and the MDS nurse was expected to review MD recommendations and care plan them. 3. Resident #5 was admitted to the facility on 3/26/19 with diagnoses of failure to thrive, diabetes, and severe malnutrition. Her most recent Minimum Data Assessment, an admission assessment, dated 4/2/19 revealed she was moderately cognitively impaired, and she required extensive assistance with turning in bed, transfers to and from the bed, and toileting; and she had occasional, moderate pain. The assessment further revealed she had a stage one pressure ulcer.	F 686		

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A review of the Treatment Administration Record for 3/2019 revealed Resident #5 did not receive treatments to her right or left heels.
A review of the Nurse's Admission Note dated 3/27/19 at 1:20 PM by Nurse #2 indicated Resident #5 was admitted on 3/26/19 at 10:30 AM. The note further indicated Resident #5 had a pressure ulcer to her right heel. The Admission Note did not indicate the stage or size of the ulcer.

A Nurse's Note dated 3/27/19 at 7:51 PM by nurse #2 revealed the resident had a pressure ulcer to her right heel. The note did not reveal the stage or measurements of the right heel pressure ulcer.

The Treatment Administration Record for 4/2019 revealed Resident #5 received a treatment of Povidone-Iodine to right heel deep tissue injury topically every evening shift on 4/11/19. The Treatment Administration Record also revealed Resident #5 began the same treatment to the left heel for a deep tissue injury on 4/11/19.

A Weekly Pressure Ulcer Report completed on 4/3/19 at 3:48 PM by Nurse #1 indicated Resident #5 had a possible deep tissue injury to her right heel and a note was placed in the Wound Physician's book to evaluate the wound.

A review of the Wound Evaluation and Management Summary by the Wound Physician dated 4/10/19 revealed Resident #5 had an Unstageable Deep Tissue Injury to her right heel that measured 4 centimeters length by 6.1 centimeters width. The report also revealed Resident #5 had an Unstageable Deep Tissue

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Injury to her left heel that measured 0.7 centimeters length by 1.2 centimeters width.

A review of the Physician's Orders revealed Resident #5 had an order dated 4/11/19 for Povidone-Iodine Swab apply to right and left heel Deep Tissue Injury (DTI) every evening and cover with a dry dressing.

On 4/11/19 at 1:55 PM a Weekly Pressure Ulcer Reported completed by Nurse #1 revealed Resident #5 had a suspected deep tissue injury to her right heel. The wound measurements were recorded as 4 centimeters length by 6.1 centimeters width.

The Wound Evaluation and Management Summary by the Wound Physician dated 4/17/19 indicated Resident #5 had an Unstageable Deep Tissue Injury to the right heel that measured 4 centimeters length by 5.1 centimeters width. The report further revealed Resident #5 had an Unstageable Deep Tissue Injury of the left heel that measured 2.6 centimeters length by 2.5 centimeters width.

A Weekly Pressure Ulcer Report completed 4/18/19 at 10:35 AM by Nurse #1 revealed Resident #5 continued to have a suspected deep tissue injury. The wound measurements were recorded as 2.6 centimeters length by 2.4 centimeters width.

On 4/22/19 at 3:05 pm during an observation of Resident #5's right heel wound dressing change Nurse #1 stated the right heel wound was a deep tissue injury and had been present on admission.

During an interview on 4/22/19 at 4:22 pm with

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F 686	Continued From page 30 Nurse #1 she stated Resident #5's right heel was a possible deep tissue injury on admission and was unstageable. Nurse #1 also stated Resident #5 had not been seen by the Wound Physician on 3/27/19 or 4/3/19 when he visited the facility. She stated the Wound Physician measures and stages all wounds when he visits the facility once a week and she uses his measurements and staging in her notes. Nurse #1 stated she did not know how the weekly measurements and staging would be done if the Wound Physician does not visit as scheduled. An interview with the Wound Physician on 4/22/19 at 6:20 pm revealed he was not notified of Resident #5's pressure ulcers on her heels until he saw her on 4/10/19. He stated both heels were deep tissue injuries which would make them unstageable. The Wound Physician stated he does the wound measurements and staging for the facility and rarely misses a visit to the facility. He stated Resident #5's wounds were worse since he began treating her, but she had many barriers to healing such as her age and physical limitations. An interview with the Director of Nursing (DON) on 4/23/19 at 9:57 am revealed Resident #5 had the right heal pressure ulcer that was not staged by the nursing staff or the wound physician on admission. The DON stated the wound should have been staged and measured on admission, and orders for treatment obtained. She further stated she should have been notified the Wound Physician did not assess Resident #5 on his visits on 3/27/19 and 4/3/19 so that she could have ensure the wound was staged and measured.	F 686		
F 732	Posted Nurse Staffing Information	F 732		5/18/19

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§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.

§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.

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F 732	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed staff in 8 of 20 daily posted nurse staffing sheets and failed to have posted nurse staffing sheets completed for 1 of 2 days during the survey. Findings included: 1. Review of the facility's daily nurse staffing forms and daily nurse schedules for 4/1/19 to 4/20/19 revealed the following daily nurse staffing forms were not accurate: 4/3/19, 4/6/19, 4/7/19, 4/8/19, 4/14/19, 4/15/19, 4/17/19, and 4/20/19. a. The Nursing Schedule dated 4/3/19 for the facility was reviewed and indicated there was no Restorative Aide (RA) on 1st shift (7:00 AM to 3:00 PM) but a Restorative Aide was indicated on the Daily Nurse Staffing form for 1st shift. The Nursing Schedule also indicated there were 7 Nurse Aides (NA) on 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form noted no Nurse Aides were scheduled on 2nd shift. b. The Nursing Schedule dated 4/6/19 for the facility was reviewed and it indicated 1 Registered Nurse (RN) and 8 NAs were scheduled for 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form indicated there were 2 RNs and 7 NAs on 2nd shift. The Nursing Schedule further indicated there were 2 Licensed Practical Nurses (LPN) on 3rd shift (11:00 PM to 7:00 PM) but the Daily Nurse Staffing form indicated there was 1 RN and 1 LPN on 3rd shift.	F 732	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. 1. Corrective action has been accomplished for the alleged deficient practice regarding proper posting of per shift per day Licensed Nurse & Unlicensed Staff (Nurse Staff Information). On 04/26/2019 the facility scheduler was in-serviced on the proper calculations/posting of licensed and unlicensed nursing staff to the per shift per day posted Nurse Staff Information. On 04/26/2019 the Nurse Staff Information posting was corrected to reflect the current census and scheduled current staff. 2. The facility will ensure residents having the potential will not be affected by the alleged deficient practice. On 4/23/2019 thru 05/12/2019 a collaborative effort between the facility medical records and scheduler initiated in-services for interdepartmental team, registered/licensed nursing staff, managers-on-duty, and receptionist(s) on the proper calculations/posting of licensed and unlicensed nursing staff to the per	

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F 732	Continued From page 33 c. The Nursing Schedule dated 4/7/19 for the facility was reviewed and it noted no RN and 8 NAs for 1st shift (7:00 AM to 3:00 PM) but the Daily Nurse Staffing form indicated there was 1 RN and 7 NAs on 1st shift. The Nursing Schedule further noted there were 2 LPNs and no RNs for 3rd shift (11:00 PM to 7:00 AM) but the Daily Nurse Staffing form noted there was 1 RN and 1 LPN on 3rd shift. d. The Nursing Schedule dated 4/8/19 for the facility was reviewed and it noted 2 LPNs and 1 Certified Medication Aide (CMA) for 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form noted there were 3 LPNs for 2nd shift. e. The Nursing Schedule dated 4/14/19 for the facility was reviewed and it noted 2 LPNs on 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form noted there were 3 LPNs on 2nd shift. f. The Nursing Schedule dated 4/15/19 for the facility was reviewed and it indicated there were 6 NA on 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form indicated there were 7 NAs on 2nd shift. g. The Nursing Schedule dated 4/17/19 for the facility was reviewed and it noted there were 7 NAs for 1st shift (7:00 AM to 3:00 PM) but the Daily Nurse Staffing form indicated there were 8 NAs on 1st shift. The Nursing Schedule for 4/17/19 further indicated there were 5 NAs on 2nd shift (3:00 PM to 11:00 PM) but the Daily Nurse Staffing form indicated there were 6 NAs on 2nd shift.	F 732	shift per day posted Nurse Staff Information. 3. Measures put in place to ensure the alleged deficient practice does not recur include: Completion of the Monday thru Friday weekly Nurse Staff Information performed by the facility Harmony Hall 1st shift LPN, Unit Manager and 3rd shift RN. Completion of the Saturday thru Sunday weekend Nurse Staff Information performed by the facility Harmony Hall 7A -7P RN, and the facility Transitional Hall 7A-11P LPN. Audits of the Monday thru Friday weekly Nurse Staff Information performed by the facility scheduler, medical records, and administrator. Audits of the Saturday thru Sunday weekend Nurse Staff Information performed the facility 8A-8P receptionist and the manager-on-duty. 4. The facility administrator will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 6 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. The Quality Assurance Committee consist of facility Administrator, Director of Nursing, Maintenance Director, Social Services Director, Activities Director, and Medical Director.	

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h. The Nursing Schedule dated 4/20/19 for the facility was reviewed and it indicated there was not a restorative aide scheduled on 1st shift (7:00 AM to 3:00 PM) but the Daily Nurse Staffing form indicated there was a restorative aide on 1st shift.

An interview with the Nursing Scheduler on 4/23/19 at 9:00 AM revealed she was not aware the Posted Nurse Staffing forms were not accurate. She stated she enters the number of staff that are scheduled to work on the form for 1st shift (7:00 AM to 3:00 pm) and the Unit Manager or the Nurse should update the number if there are call outs or they have extra staff. She stated the on 2nd shift (3:00 PM to 11:00 PM) and 3rd shift (11:00 PM to 7:00 AM) the Nurse should update the form each shift with the accurate staffing.

2. An observation of the Posted Nurse Staffing on 4/22/19 at 4:30 PM revealed the 3:00 PM to 11:00 PM nurse staffing had not been recorded on the posted form.

During an interview on 4/23/19 at 9:00 AM with the Nursing Scheduler she stated the Unit Managers and Nurses update the Posted Nurse Staffing form each shift. She stated she does fill in the schedule for the number of staff that are scheduled to work for 1st shift (7:00 AM to 3:00 PM) but when there is a call out or they have extra staff the Unit Manager or the Nurse will update the Posted Nurse Staffing form.

On 4/23/19 at 9:57 am an interview with the Director of Nursing (DON) revealed the Unit Managers should be updating the Posted Nurse Staffing form with the correct staffing totals each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345520	A. BUILDING _____ B. WING _____	C 04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT THOMASVILLE TRANSITIONAL CARE & REHAB	1028 BLAIR STREET THOMASVILLE, NC 27360

(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 732	Continued From page 35 shift for 1st shift (7:00 AM to 3:00 PM) and the 100 hall Nurse updated the form on the 2nd shift (3:00 PM to 11:00 PM) and the 3rd shift (11:00 PM to 7:00 AM). The DON stated she expected the Posted Nurse Staffing form and the Nurse Schedule to reflect the accurate number of nursing staff in the facility. An interview with the Administrator on 4/23/19 at 10:14 am revealed his expectation would be Posted Nurse Staffing would be posted correctly and updated each shift.	F 732		