STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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
E 000	Initial Comments An unannounced Recertification survey was conducted from 4/29/19 through 5/2/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness . Event ID BOXN11.	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident ' s call light within reach and provide an appropriate type of call bell to allow for the resident to use at all times to request staff assistance if needed for one of two resident reviewed for accommodation of needs (Resident #304). The findings included: Resident #304 was admitted to the facility on 5/26/16 and most recently readmitted on 4/23/19 with multiple diagnoses that included contractures of muscles multiple sites, postural spasticity, cerebral infraction, major depression and generalized anxiety. The admission Minimum Data Set (MDS) assessment dated 4/30/19 indicated Resident # 304 was cognitively intact, unclear speech and	F 558	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Corrective action the resident found to have been affected by the deficient practice: On 5/2/2019, the Housekeeping Manager provided resident #304 with a flat-pad call light that she can operate by placing her hand on it. A cord clip was also provided to help keep the call light cord in place.	5/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2019

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F 558	Continued From page 1 usually could make self-understood. Resident # 304 required assistance of 2 or more staff and was totally dependent with bed mobility, transfers, locomotion on/off unit, toileting, and personal hygiene. Resident was impaired on both sides for upper and lower body regarding range of motion and was on physical and occupation therapy. Review of Resident# 304 ' s plan of care, last reviewed 5/1/19, indicated the resident was care planned for activities of daily living deficit related to total immobility and severe contractures of all extremities and care planned for difficulty communication related to unclear speech. An observation and interview was conducted with Resident #304 on 4/29/19 at 9:20 PM, Resident #304 was lying on her back in bed and appeared alert. The resident's call light and the cord were observed on the floor, out of resident's reach. The resident indicated she could use the call bell to call staff for assistance but was unsure where her call bell was at this time. Resident indicated she was totally dependent on staff for most of her activities of daily living (ADL) needs. An observation was conducted of Resident #304 on 4/30/19 12:38 PM. The resident was observed in her room in bed. Resident #304 ' s call light cord and call bell were on the floor, out of her reach. An observation and interview of Resident #304 on 05/01/19 10:00 AM revealed the resident was in her room, lying in her bed and had splints on both her hands. The call bell was to the side near her right shoulder. An interview with the resident revealed the resident was unable to access or	F 558	Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/2/2019, all other residents call lights were checked and observed by the Director of Health Services, Unit Managers, Charge Nurses and, department heads. All call lights were found to be appropriate for resident needs and were within reach. Clips for call light cords were made available by the Maintenance Director where they were needed. More cord clips and alternative call lights (pressure and flat pad) are available in the facility should they be needed. Systemic changes made to ensure that the deficient practice will not recur: 100% in-service was initiated on 5/3/2019 by the DHS, Clinical Competency Coordinator and, the Administrator for all staff on ensuring that call lights are appropriate and within reach of residents. In-service will be completed by 5/28/2019. Staff who have not completed the in-service will not be allowed to work until they are in-serviced. All newly hired employees will be educated on ensuring that call lights are appropriate and within reach of residents during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Floor nursing staff (nurses and aides) are mainly responsible for ensuring the call lights are appropriate and within	

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F 558	Continued From page 2 use the call bell with splints on her both of her hands. Resident stated she was unable to reach or press the call bell as she could not move her hand or fingers. During an interview on 05/01/19 10:00 AM, Nursing Aide (NA) #3 indicated she was familiar with Resident # 304 and the resident had recently returned from the hospital. NA# 3 indicated resident's voice was very low, unclear speech due to recent hospitalization, but was able to communicate her needs. NA# 3 stated Resident # 304 was able to use his call light to request staff assistance. The NA indicated she normally placed Resident #304 ' s call light near her chest so she was able to reach it. She was unsure how resident could use the call bell with her splints on both of her hands. During an interview and observation on 5/1/19 10:35 AM, Nurse # 10 stated Resident # 304 had returned from hospital a week ago, had splints prior to hospitalization for her contractures and did not have splints after the resident's returned. Nurse added the resident had a very low voice, had communication difficulty and could communicates her needs to staff. Nurse #10 indicated resident was able to call for assistance by using the call bell. During the resident's observation Nurse#10 indicated she was unaware therapy was trying out new splints for the resident. The nurse was unable to state how the resident would use the call bell with her splints on both of her hands. Nurse #10 stated Resident # 304 may need a touch pad call bell if the resident needs to wear splints on both of her hands. The Nurse further stated the NA assigned to the resident should be checking to make sure the call bell was functional and within reach of the	F 558	reach of residents. A call light tool was introduced by the Administrator and will be utilized on weekdays to check call lights by department heads and/or designated staff during compliance rounds twice a day for 1 week, then 1x a day for 1 month until 3 consecutive months of compliance. On weekends, floor nursing staff including supervisors, charge nurses and nursing aides are responsible for ensuring the call lights are appropriate and within in reach of residents. Plans to monitor its performance to make sure that solutions are sustained: The Administrator and the Director of Health Services will review the clinical rounds tool weekly for a month until compliance is maintained. The Administrator and the Director of Health Services will conduct random checks to ensure call lights are appropriate and within reach of the resident. The Administrator will report any findings of non-compliance to Quality Assurance and Performance Improvement committee monthly for further recommendations as needed until compliance is maintained. Date of Compliance: 5/28/2019	

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F 558	Continued From page 3 resident. During an interview on 5/1/19 at 1:28 PM, Occupation Therapist (OT) stated the resident was evaluated for splints upon return from the hospital and new splint testing was in progress. OT stated the certified occupation therapy assistant (COTA) was responsible of applying the splints for the Resident# 304 during the testing period. OT added the COTA should inform the assigned nurse when splints where applied for the resident. During an interview on 5/2/19 at 3:55 PM, the COTA stated she had applied splints for Resident # 304 and had not communicated it to the nurse. COTA was unable state how the resident could use the call bell and indicated the resident would need to be provided with a touch pad for call bell to allow her to utilize a call bell even when she was wearing splints on both of her hands. An interview was conducted with the interim Director of Nursing (DON) on 05/02/19 at 04:01 PM regarding Resident # 304 ' s call light not being placed within her reach and resident unable to use the call bell when splints were placed on her both of her hands. The DON indicated her expectations were for staff to place resident's call bell within reach at all times. She further stated that appropriate kind of call bell should be used so that the resident could call for assistance when on splints. DON added there should be appropriate communication between therapy and nursing staff.	F 558		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		5/28/19

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F 638	Continued From page 4 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly assessment for 1 of 24 residents who had Minimum Data Set (MDS) assessments reviewed (Resident #355). Findings included: Resident #355 had been originally admitted on 9/19/18. His diagnoses included abnormal posture and muscle weakness. Resident #355's admission MDS assessment had been completed on 9/26/18 and indicated he was cognitively intact. He did not ambulate and required extensive to total assistance with activities of daily living. Record review revealed the next completed MDS assessment for Resident #355 was a quarterly dated 2/7/19. On 5/02/19 at 9:39 AM an interview with the MDS nurse was conducted. The nurse stated when Resident #355 had returned from the hospital, 5 day and a 14 day MDS assessments had been completed for insurance payment only. The nurse stated a quarterly MDS assessment should have been completed with the 14 day assessment. The nurse stated a quarterly MDS assessment should have been completed in December 2018 for Resident #355.	F 638	Corrective action the resident found to have been affected by the deficient practice: Resident #355 still resides in the facility. The quarterly assessment was completed on 5/2/2019 by the MDS Director. Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/3/2019, the MDS Director and the MDS Coordinator together with the Administrator and the Director of Health Services reviewed quarterly MDS assessments to ensure there were no other late assessments. The MDS Director and the MDS Coordinator reviewed the assessments calendar with focus on late assessments. The Interdisciplinary Team (IDT) was provided with the calendar to ensure each discipline completes their part in the quarterly MDS assessment. On 5/3/2019, the Administrator and the Director of Health Services initiated education for the IDT (including MDS nurses, the Social Worker, the Director of Recreational Services and, the Dietary Manager) on the requirement of completing quarterly MDS assessments not less frequently than once every 3	

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F 638	Continued From page 5 On 5/02/19 at 9:57 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she would expect the MDS assessments to be completed on time.	F 638	months. Education was completed on 5/21/2019. Any new hires to join the IDT will be educated on the requirement of completing quarterly MDS assessments not less frequently than once every 3 months by the Administrator and/or the Director of Health Services during new hire orientation. Any late quarterly assessments identified will be completed by 5/25/2019 by MDS nurses. Systemic changes made to ensure that the deficient practice will not recur: On 5/3/2019, the Administrator and the Director of Health Services initiated education for the IDT (including MDS nurses, the Social Worker, the Director of Recreational Services and, the Dietary Manager) on the requirement of completing quarterly MDS assessments not less frequently than once every 3 months. Education was completed on 5/21/2019. Any new hires to join the IDT will be educated on the requirement of completing quarterly MDS assessments not less frequently than once every 3 months by the Administrator and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services and MDS Nurses will review due assessments 5 days a week for 4 weeks on a continuing basis to ensure assessments are completed and transmitted timely. MDS nurses have been informed by the Administrator of their responsibility to keep the assessments calendar up-to-date.	

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F 638	Continued From page 6	F 638	Plans to monitor its performance to make sure that solutions are sustained: The Administrator, the Director of Health Services and MDS Nurses will review assessments due during daily standup meeting for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement committee quarterly and/or as needed for recommendations to ensure compliance is maintained. Date of Compliance: 5/28/2019	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640		5/28/19

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F 640	Continued From page 7 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit an entry tracking Minimum Data Set (MDS) assessment within the required time frame for 1 of 24 residents reviewed for submission of MDS assessments (Resident #355).	F 640	Corrective action the resident found to have been affected by the deficient practice: Resident #355 still resides in the facility. The resident□s entry tracking assessment was completed and transmitted on 5/2/2019 by the MDS Director.	

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F 640	Continued From page 8 Findings included: Resident #355 had been originally admitted on 9/19/18. His diagnoses included abnormal posture and muscle weakness. Resident #355's admission MDS assessment was completed on 9/26/18 and indicated he was cognitively intact. He did not ambulate and required extensive to total assistance with activities of daily living. Review of Resident #355's medical record revealed he was discharged, with return anticipated on 12/11/18. Resident #355 was readmitted to the facility on 12/18/18. No MDS entry tracking assessment for 12/18/18 was found in the resident's medical record. The next completed MDS assessment in Resident #355's medical record was dated 2/7/19. On 5/02/19 at 9:39 AM an interview with the MDS nurse was conducted. The nurse stated Resident #355 was readmitted to the facility on 12/18/18 and a MDS entry tracking asssment should have been completed at that time, but it was overlooked and not completed. On 5/02/19 at 9:57 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she expected the MDS assessments to be completed on time.	F 640	Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/3/2019, the MDS Director, MDS Coordinator and, the DHS initiated review of all admissions and readmissions since 12/1/2018 for entry tracking assessments. The review will be completed by 5/24/2019 and any entry assessments not completed, will be completed and transmitted by 5/28/2019 by the MDS nurses. Systemic changes made to ensure that the deficient practice will not recur: On 5/3/2019, the Administrator and the Director of Health Services initiated education for MDS nurses on the requirement of completing and transmitting entry tracking assessments timely as specified by the state and approved by CMS. Education was completed on 5/21/2019. Any newly hired MDS staff will be educated on the requirement of completing and transmitting entry tracking assessments timely as specified by the state and approved by CMS by the Administrator and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services and MDS Nurses will review all new admissions and readmissions 5 days a week for 4 weeks on a continuing basis to ensure entry tracking assessments are completed and transmitted timely. MDS	

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F 640	Continued From page 9	F 640	nurses have been informed by the Administrator of their responsibility of ensuring entry tracking assessments are completed and transmitted in the format specified the state and approved by CMS. Plans to monitor performance to make sure that solutions are sustained: The Administrator, the Director of Health Services and MDS Nurses will review entry and reentry tracking assessments for all new admissions and readmissions during daily standup meeting for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement committee quarterly and/or as needed for recommendations to ensure compliance is maintained. Date of Compliance: 5/28/2019	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to assist a resident to make appointments with a	F 658	Corrective action the resident found to have been affected by the deficient practice:	5/28/19

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F 658	Continued From page 10 rheumatologist and for podiatry services for 1 of 1 resident reviewed for need for specialized services (Resident #103). Findings Included: 1. Resident #103 was admitted to the facility from the hospital on 10/11/18 with diagnosis in part, of rheumatoid arthritis (RA). Resident #103's hospital discharge order dated 10/10/18 specified, "He should follow up with rheumatologist as outpatient for improved management of his RA which is fairly debilitating." The most recent quarterly Minimum Data Set dated 4/15/19, revealed he was cognitively intact with no long or short term memory problems. He was dependent on staff for daily dressing, toileting and hygiene, had limited range of motion on upper and lower extremities of one side of his body. He used a wheelchair for mobility. During interview on 04/30/19 at 10:49 AM Resident #103 stated he wanted to see his rheumatologist and the facility had not made any appointments. He stated he usually went regularly, but had not seen the rheumatologist since being admitted to the facility Observation revealed on 4/30/19 at 10:49 AM both hands had severely contracted fingers from arthritis. Also, his shoes had been cut to accommodate the deformity of his feet. During an interview on 05/01/19 at 10:42 AM, Nurse #4 stated on 4/15/19 Resident #103 had asked to see his Rheumatologist. She called the Rheumatology clinic on 4/15/19 to set up an appointment. She was informed that he had a routine appointment that had been scheduled for	F 658	Resident #103 still resides in the facility. On 4/15/2019, a rheumatologist appointment was scheduled by the charge nurse for 7/1/2019 -the earlier available appointment. The podiatry appointment was scheduled for 5/21/2019 by the Unit Manager. Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/6/2019 the DHS, Unit Managers and, charge nurses conducted a review of all current resident charts for physician orders and/or recommendations for specialized services and follow up appointments. The review of orders was completed on 5/9/2019. No residents were found to have missed any follow up appointments and/or recommendations as ordered by the physician. Systemic changes made to ensure that the deficient practice will not recur: The Director of Health Services together with the clinical team (including but not limited to Unit Managers/Supervisors and the Interdisciplinary team) will review all orders for new admissions and readmissions daily during the clinical rounds. The Director of Health Services and the Clinical Competency Coordinator initiated education on 5/3/2019 for all licensed nurses on following physician orders and/or recommendations to ensure appointments and referrals are made as ordered. The education will be completed	

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F 658	Continued From page 11 4/15/19. Nurse #4 rescheduled the appointment for 7/1/19. During interview on 05/02/19 at 06:08 AM Nurse #9 reviewed the discharge summary dated 10/10/18 and indicated that Resident # 103 rheumatology appointments should have been made by facility when he was admitted to the facility on 10/11/18. He stated Nurse #4 was responsible for making resident appointments and following up on resident's appointments. During an interview on 5/2/19 at 9:50 AM Nurse #4 stated that on reviewing Resident #103's hospital discharge paper work dated 10/10/18 an appointment should have been set up for the resident to see the rheumatologist. She went on to say that Resident #103 was alert and oriented at times and his own responsible party. The nurse further stated the resident could tell staff when he needed to see the rheumatologist. 2. Record review of physician order dated 3/27/19 revealed, "Consult podiatry for bilateral foot deformities due to RA (Rheumatoid Arthritis)." Record review of Social Worker (SW) email confirmation of podiatry referral was dated 5/1/19. During an interview on 05/01/19 at 10:22 AM Nurse #8 indicated that podiatry comes into the facility to see residents. The SW sets up the resident's podiatry appointment. During an interview on 5/2/19 at 9:55 AM SW indicated that the podiatrist was at the facility on 4/23/19, last week. She stated she received the referral from nursing for Resident #103 on 5/1/19, and sent it to the consulting podiatrist. The SW	F 658	by 5/25/2019. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on following physician orders and/or recommendations to ensure appointments and referrals are made as ordered during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. A 24-hour chart check will be conducted for new admissions and readmissions by Unit Managers or Supervisors. Clinical rounds will be conducted 5 days a week by the clinical team to ensure physician orders are being followed. Plans to monitor its performance to make sure that solutions are sustained: The Director of Health Services and/or Nurse Managers will validate the 24-hour chart check given to them by the Charge Nurses daily for 5 days then weekly thereafter for 4 weeks then monthly until 6 consecutive months of sustained compliance is obtained. The Director of Health Services will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee quarterly and/or as needed for further recommendations to ensure compliance is maintained. Date of Compliance: 5/28/2019	

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F 658	Continued From page 12 explained the resident wasn't seen on 4/23/19 because she didn't know about the podiatry order. She presented an email and stated, "I sent the request on 5/1/19 at 1:48PM via email." During an interview on 5/2/19 at 10:00AM by phone, the podiatry consult scheduler stated she received the referral 5/1/19. Resident #103 was scheduled to be seen on the next facility appointment. During interview on 5/2/19 at 1:15PM Nurse #4 indicated that the order dated 3/27/19 for podiatry to see Resident #103 was copied and given to the social worker on the same day it was ordered. During an interview on 5/2/19 at 5:30 PM the Director of Nursing stated she had to look into the situation.	F 658		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		5/28/19

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F 688	Continued From page 13 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to apply a splint to left leg, left elbow and a "carrot" splint to left hand for 1 of 4 residents who were sampled for splint application (Resident # 72). Findings included: Resident #72 was admitted on 4/30/16 with diagnosis in part of hemiplegia and a seizure disorder. Record review of the care plan dated 1/17/19 revealed, the problem was to assist with left hand carrot splint as tolerated (will remove splint himself at times.) the goal was to prevent left hand contracture. The approach was to assist resident with application accord to the schedule wearing time and to monitor resident skin under the devices for irritation or breakdown. Record review of physician order dated 1/21/19 OT (occupational therapy) clarification patient to wear LUE (left upper extremity) elbow extension orthosis & hand carrot (a soft cylinder splint to prevent finger contractures) orthosis per skilled OT personnel/doffing(take off) as indicated to address contracture management via orthotic tolerance training and trialing effective 12/27/18 Record review revealed a physician's order dated 2/6/19 to discontinue skilled OT services effective this date and continue with functional maintenance for LUE splinting to put on LUE Extension &carrot orthoses at bedtime then take off in AM after max of 8 continuous hours or as tolerated. Record review revealed a physician's order dated 3/21/19 for "Patient to wear left ankle PRAFO boot as tolerated in bed overnight apply	F 688	Corrective action the resident found to have been affected by the deficient practice: Resident #72 still resides in the facility. The resident continues therapy and the orders for splints are still in place and being followed by nurses as ordered. The splints are being applied as ordered. The Unit Manager and charge nurses are ensuring the splints are applied. The Director of Health Services and the clinical team review the documentation and physically observe the splints on resident during clinical rounds. Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/6/2019, the DHS and Unit Managers reviewed all residents with contractures and referred them to therapy for evaluation for splints or other recommendations as needed. The review and referral of residents with contractures will be completed by 5/25/2019. After the review, therapy will recommend a plan of care as needed and educate nurses and nursing aides on the recommendations. The Director of Health Services and Unit Managers will be responsible checking during morning clinical rounds to ensure that splints are applied as recommended. Residents care plans and care guides will be updated as needed.	

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F 688	Continued From page 14 at bedtime and remove in morning" Record review of the physical therapy discharge summary dated 3/22/19 revealed in part, "Patient with left ankle orthosis and wearing schedule in place." The most recent Minimum Data Set dated 4/9/19 revealed he was severely impaired, had no rejection of care behavior. He was dependent on staff for daily dressing, toileting and hygiene, had limited range of motion on upper and lower of one side of his body. He used a wheelchair for mobility. He had not received any occupation or physical therapy or splint application during this assessment period. Observation on 04/30/19 at 10:07 AM revealed Resident #72 had a left hand contracture that was severe. He had left sided paralysis of his left leg which was resting on wheelchair foot rest. Record review of current C.N.A (certified nursing assistant) care guide record not dated reviewed revealed carrot to left hand, left ankle PRAFO (pressure relief ankle foot orthosis) boot at night as tolerated apply bedtime and remove in morning. Record review on 5/2/19 revealed on treatment administration record (TAR) dated April 2019 documented, "Apply LUE brace at 7PM and wear as tolerated through night." In the documentation area it indicated in pen to see medication administration record (MAR). There was no splint application documented on the April 2019 MAR or TAR. The MAR documentation revealed no behaviors on all shifts. Record review on 5/2/19 revealed on treatment administration record (TAR) dated May 2019 revealed "Apply LUE brace at 7PM and wear as tolerated through night." In the documentation area it indicted in pen to see medication	F 688	Systemic changes made to ensure that the deficient practice will not recur: The Director of Health Services and the Clinical Competency Coordinator initiated education for charge nurses and Unit Managers/supervisors on applying splints as recommended by therapy. Nurses who are not educated, will not be allowed to work until they are educated. Resident care plans and nurse aide care guides will be updated as needed during the morning clinical rounds. Any resident showing any signs of contracting will be referred to therapy by the charge nurse. Therapy will evaluate and make recommendations as needed for nurses to follow. Plans to monitor its performance to make sure that solutions are sustained; The Director of Health Services and Nurse Managers will review residents with splints daily for 5 days then weekly thereafter for 4 weeks then monthly until 6 consecutive months of sustained compliance is obtained. The Director of Health Services will present any findings of non-compliance to the Quality Assurance and Performance Improvement committee quarterly and/or as needed for further recommendations to ensure compliance is maintained. Date of Compliance: 5/28/2019	

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F 688	Continued From page 15	F 688		

administration record (MAR). No splint application was documented on the Monthly May 2019 MAR or TAR. The MAR documentation revealed no behaviors on all shifts.
Record review on 5/2/19 of nursing notes revealed no notes to indicate status of night splinting compliance.
During am observation on 05/02/19 at 06:02 AM at Resident #72 was observed sitting in his room on his bed without any splinting to his left arm, foot or hand

During interview and observation on 5/2/19 at 6:02AM Nurse #9 stated if a resident required a splint application from 11:00 PM -7:00 AM he put the splints on the resident. He stated that he had not applied any splints to Resident # 72. He stated during the day Nurse # 4 applied the splints. He looked for splints in the room and there were none. He stated that the order was not on the May 2019 monthly MAR or the monthly May 2019 TAR. He reviewed the order for 3/21/19 and stated that the order was discontinued on the 3/19 TAR for the left leg splint. After review of the 3/21/19 order he stated that resident should have had this splint. He stated that Nurse #4 would know more, she carried out the order transcription and nurse #8 managed the unit.

During interview and observation 05/02/19 at 06:25 AM Nursing Assistant (NA) #1 indicated that she cared for Resident # 72 at night. She stated that he didn't wear a splint at night. They took the splint off before she arrived. She looked for any kind of splint in his room and stated she was unable to locate any splints.

During an interview on 5/2/19 at 9:42 AM Nurse #

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F 688	Continued From page 16	F 688		

8 stated Resident #72 was supposed to wear a boot at night time. She specified, I don't know where they document that he wore the boot. He doesn't wear an upper body device or use a carrot because he refused to wear both the lower and the upper appliances.
During an interview on 5/2/19 at 9:43AM Nurse # 4 stated Resident #72 was supposed to wear a boot, on his left foot, but she did not remember it being in a careplan.
During an interview on 5/2/19 at 1:22PM Physical Therapist indicated Resident #72 was ordered to wear a night split. Pressure reducing ankle foot orthosis (PRAFO) at night. The nursing staff were trained and were responsible to put it on and take it off, since 3/22/19.
During an interview on 5/2/19 at 1:27PM Occupational Therapist stated Resident #72 used a carrot splint and had an elbow splint to the LUE. There was a written order in the chart. On 2/6/19 was when nursing was trained to apply these splints.
During an interview on 05/02/19 at 03:28 PM NA #2 stated she worked days and evenings with Resident #72. He had splints and therapy put them on in the morning. NA #2 further stated that she didn't know when Resident #72's splints were put on or taken off. The aide added, that she didn't know where to look to find out.

During an interview on 5/2/19 at 4:55 PM Nurse # 4 indicated there was currently no restorative nursing program at the facility the nursing staff were trained by the therapy department on splint application and they were to put the splints on the resident. The information for splint application was on the MAR or the TAR or the C.N.A care card guide, which was located in the computer.

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F 689	Continued From page 17	F 689		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility did not enforce the was smoke-free facility rules, allowed independent resident smokers to smoke on facility property, failed to provide a place to extinguish smoking material, and a did not provide a safe smoking area for residents during smoking activities for 3 of 4 residents reviewed for accidents (Resident #24, #79, and #356). Findings included: 1. Resident #24 had been admitted on 5/24/18. The facility's Smoke Free Policy indicated as of 1/01/15 smoking was not allowed on the premises. Smoking would only be allowed for residents who had been "grandfathered" in prior to 1/01/15. The Admission Agreement dated 5/24/18 indicated Resident #24's Representative had received a copy of the Guest Services Guide and had accepted all terms and conditions stated in this agreement and in the Guest Services Guide. A copy of the Guest Services Guide was reviewed. The guide indicated the facility	F 689	Corrective action the resident found to have been affected by the deficient practice: Resident # 79 and #356 no longer reside in the facility. Resident #24 still resides in the facility. Residents were notified individually on 5/16/2019 by the Administrator and the Director of Health Services of the requirement to abide by the facility policy with emphasis on not smoking on facility property/premises. Resident #24 was also notified that non-compliance with the facility policy will lead to a 30-day discharge notice being issued by the facility. A meeting to include the Ombudsman is scheduled for 5/30/2019 for all smoking residents. A meeting for all residents who smoke was scheduled for 5/23/2019 at 2:00pm with the Administrator, the Director of Health Services and, the Director of Social Services to emphasize following the smoking policy requirements. Residents can smoke on the sidewalk	5/28/19

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F 689	Continued From page 18 prohibited the use of all forms of tobacco. Resident #24's care plans initiated on 5/24/18 and updated on 4/29/19 indicated he did not require supervision with smoking as he was independent with mobility, alert and oriented. Interventions included to educate Resident #79 that there was no smoking on the facility property. Resident #24's admission Minimum Data Set dated 5/31/18 indicated he was cognitively intact. He was independent or required supervision/set up assistance with his activities of daily living. The assessment did not indicate Resident #24 used tobacco. A Leave of Absence/Release From Responsibility Form for Resident #24 was reviewed. The form indicated " ... the resident is leaving, accepts complete responsibility for [themselves] while away from the center, and absolves the center, its management, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is away." The form included areas for the resident to date, time and sign in and out of the facility. Multiple entries were observed for Resident #24. A Smoking Observation Form dated 4/29/19, filled out by with admitting nurse, indicated Resident #24 had been assessed as safe to smoke unsupervised. An observation was made of the facility parking lot on 4/30/19 at 9:10 AM. A no parking zone, indicated by yellow stripes painted on the pavement, was noticed to have many cigarette butts discarded both on the pavement and in the	F 689	(public area) or away from the property. The Ombudsman has been invited to a meeting on 5/30/2019 with smoking residents, the Administrator, the Director of Health Services and, the Director of Social Services to again emphasize the need to comply with the facility smoking policy. Residents who do not comply with will be issued a 30-day discharge notice and while still in the facility, smoking privileges will be revoked. Corrective action for other residents having the potential to be affected by the same deficient practice: A meeting for all residents who smoke was scheduled for 5/23/2019 at 2:00pm with the Administrator, the Director of Health Services and, the Director of Social Services to emphasize following the smoking policy requirements. Residents were notified that they can only smoke on the sidewalk (public area) or away from the property and not in the parking lot. The Ombudsman has been invited to a meeting on 5/30/2019 with smoking residents, the Administrator, the Director of Health Services and, the Director of Social Services to again emphasize the need to comply with the facility smoking policy. Residents who do not comply with will be issued a 30-day discharge notice and, while still in the facility, smoking privileges will be revoked. Education for staff was initiated on 5/13/2019 by the Administrator, The Director of Health Services, The Clinical Competency Coordinator and, department	

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F 689	Continued From page 19 grassy area located between the parking lot and the public sidewalk. Discarded cigarette butts were also observed in the pine straw mulch around the plants near the front door. No cigarette disposal containers were observed in these areas. During an interview with the Administrator (AD) on 5/01/19 at 3:00 PM, he stated this was no-smoking facility. The AD indicated there was a smoking policy in the admission packet that the new residents would read and sign prior to admission. The AD stated that all new residents were assessed for smoking. Residents who were alert, oriented, capable of signing themselves in and out of the facility, and assessed as safe smokers, were allowed to go outside and smoke. All smoking materials were kept locked in the medication carts, and the nurse would provide them to the resident when requested. The AD also stated, based on the location of the building, residents would go to the bus stop to smoke. He stated people who were waiting for the bus would smoke and he had no control over that. The AD stated when it was hot, cold or rainy weather, people waiting for the bus would utilize the covered porch and sometimes smoke. He further stated he had no control over residents who were alert and oriented and would like to go out or who were assessed as safe smokers. The AD stated residents were not monitored in the evening or night when going outside to smoke. He stated as the facility was a no-smoking facility, the staff did not monitor the smoking residents. The AD stated he would check people at various times and remind them that this was a smoke-free facility. The AD also stated there were no ash trays or sand buckets for the cigarette butts in front of the building as this would encourage residents to	F 689	heads on helping to enforce the policy by informing residents not to smoke on the property and to report to the Administrator any residents who violate the policy. The education will be completed by 5/28/2019. Systemic changes made to ensure that the deficient practice will not recur: The Administrator, the Director of Health Services and, the Director of Social Services have informed smoking residents that they can only smoke on the sidewalk (public area) or any other place away from the property (including the parking lot). The Ombudsman has been invited to a meeting on 5/30/2019 with smoking residents, the Administrator, the Director of Health Services and, the Director of Social Services to again emphasize the need to comply with the facility smoking policy. Residents who do not comply with will be issued a 30-day discharge notice and, while still in the facility, smoking privileges will be revoked. Education for staff was conducted to help enforce the smoking policy. The Administrator and the Director of Social Services will request to attend the next scheduled resident council meeting to address the smoking policy. Plans to monitor its performance to make sure that solutions are sustained: Facility management will hold weekly meetings with all smoking residents to emphasize the need to comply with the smoking policy for 4 weeks, bi-weekly for	

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F 689	Continued From page 20 smoke. On 5/02/19 at 10:29 AM an interview with Resident #24 was conducted. He was observed standing in the facility parking lot, in the no parking zone, smoking. He stated he had been told to stand here to smoke or he could go over by the facility's street sign to smoke. He stated was unsure who had told him to stand in this area. He stated he had been in the facility for 4 or 5 months. On 5/02/19 at 4:47 PM Resident #24 had been observed sitting on his bed in his room. He stated he goes outside when he can. On 5/02/19 at 4:51 PM an interview with Nurse #2 was conducted. She stated Resident #24 was alert, oriented, able to make his needs known and mobile without any assistive devices. She stated Resident #24 smoked and went outside several times a day. On 5/02/19 at 5:24 PM Resident #24 was observed standing in the facility parking lot, in the no parking zone, smoking. When he finished his cigarette, he extinguished the cigarette butt on the pavement and left the butt. On 5/02/19 at 10:35 AM a follow up interview with the AD was conducted. He stated the no parking zone area was on the facility property. The AD further stated there were currently no residents in the facility who had been "grandfathered" in when the no smoking policy had been put into effect. The AD stated upon admission the smoking policy is explained and they are told that they must stay off of the facility property to smoke. He stated the smokers seem to end up in that part of	F 689	1 month and then monthly for 3 months until compliance is sustained. The Administrator will report any findings of non-compliance to Quality Assurance and Improvement Committee for further recommendations as needed. Date of Compliance: 5/28/2019	

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the parking area and were non-compliant with the smoking rule. He further stated he would expect the residents to follow the rules and for staff to enforce the rules and policies.

2. Resident #79 had been admitted on 3/26/19.

The facility's Smoke Free Policy indicated as of 1/01/15 smoking was not allowed on the premises. Smoking would only be allowed for residents who had been "grandfathered" in prior to 1/01/15.

The Admission Agreement dated 3/26/19 indicated Resident #79 had received a copy of the Guest Services Guide and had accepted all terms and conditions stated in this agreement and in the Guest Services Guide.

A copy of the Guest Services Guide was reviewed. The guide indicated the facility prohibited the use of all forms of tobacco.

A Smoking Observation Form dated 3/26/19, filled out by the admitting nurse, indicated Resident #79 had been assessed as safe to smoke unsupervised.

Resident #79's admission Minimum Data Set dated 4/2/19 indicated she was cognitively intact. She was independent or required supervision/set up assistance with her activities of daily living. The assessment indicated she used tobacco.

Resident #79's care plans dated 4/10/19 indicated she did not require supervision with smoking as she was independent with mobility, alert and oriented. Interventions included to educate Resident #79 that there is no smoking on

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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
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the facility property.

A Leave of Absence/Release from Responsibility Form for Resident #79 was reviewed. The form indicated " ... the resident is leaving, accepts complete responsibility for [themselves] while away from the center, and absolves the center, its management, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is away." The form included areas for the resident to date, time and sign in and out of the facility. Multiple entries were observed for Resident #79.

An observation was made of the facility parking lot on 4/30/19 at 9:10 AM. A no parking zone, indicated by yellow stripes painted on the pavement, was noticed to have many cigarette butts discarded both on the pavement and in the grassy area located between the parking lot and the public sidewalk. Discarded cigarette butts were also observed in the pine straw mulch around the plants near the front door. No cigarette disposal containers were observed in these areas.

On 4/30/19 at 9:10 AM an interview with Resident #79 was conducted. She was observed standing in the facility parking lot, in the no parking zone, smoking. When she finished her cigarette, she extinguished the cigarette butt on the curb and left the butt in the grassy area between the facility parking lot and the public sidewalk. She stated she had been allowed to go outside independently to smoke.

On 5/1/19 at 1:22 PM Resident #79 had been observed standing in the facility parking lot, in the

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no parking zone, smoking.

During an interview with the Administrator (AD) on 5/01/19 at 3:00 PM, he stated this was no-smoking facility. The AD indicated there was a smoking policy in the admission packet that the new residents would read it and sign prior to admission. The AD stated that all new residents were assessed for smoking. Residents who were alert, oriented, capable of signing themselves in and out of the facility, and assessed as safe smokers, were allowed to go outside and smoke. All smoking materials were kept locked in the medication carts, and the nurse would provide them to the resident when requested. The AD also stated, based on the location of the building, residents would go to the bus stop to smoke. He stated people who were waiting for the bus would smoke and he had no control over that. The AD stated when it was hot, cold or rainy weather, people waiting for the bus would utilize the covered porch and sometimes smoke. He further stated he had no control over residents who were alert and oriented and would like to go out or who were assessed as safe smokers. The AD stated residents were not monitored in the evening or night when going outside to smoke. He stated as the facility was a no-smoking facility, the staff did not monitor the smoking residents. The AD stated he would check people at various times and remind them that this was a smoke-free facility. The AD also stated there were no ash trays or sand buckets for the cigarette butts in front of the building as this would encourage residents to smoke.

On 5/02/19 at 10:26 AM a second interview with Resident #79 was conducted. She was observed standing in the facility parking lot, in the no

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parking zone, smoking. Resident #79 stated she had been told to smoke in this area of the parking lot but had been unsure who had told her that. She further stated she had been told if she wanted to stand in the shade, to stand on the other side of the facility's street sign, closer to the trees.

On 5/02/19 at 12:50 PM an interview with Nurse #1 was conducted. The nurse stated Resident #79 was alert, oriented, could make her needs known and was ambulatory without an assistive device. Resident #79 had been assessed as safe to smoke and would sign herself out to smoke.

On 5/02/19 at 10:35 AM a follow up interview with the AD was conducted. He stated the no parking zone area was on the facility property. The AD further stated there were currently no smoking residents in the facility who had been "grandfathered" in when the no smoking policy had been put into effect. The AD stated upon admission the smoking policy is explained and they are told that they must stay off of the facility property to smoke. He stated the smokers seem to end up in that part of the parking area and were non-compliant with the smoking rule. He further stated he would expect the residents to follow the rules and for staff to enforce the rules and policies.

3. Resident #356 had been admitted on 4/29/19.

A Minimum Data Set assessment had not yet been completed for Resident #356.

The Admission Agreement dated 4/29/19 indicated Resident #356 had received a copy of the Guest Services Guide and had accepted all

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terms and conditions stated in this agreement and in the Guest Services Guide.

A copy of the Guest Services Guide was reviewed. The guide indicated the facility prohibited the use of all forms of tobacco.

Nursing admission documentation dated 4/29/19, indicated Resident #356 was alert, oriented, followed commands, and had no exit seeking behaviors.

A Smoking Observation Form dated 4/29/18, filled out by the admitting nurse, indicated Resident #356 had been assessed as safe to smoke unsupervised.

His baseline care plan dated 4/30/19 indicated Resident #356 was a smoker. Goals included Resident #356 would demonstrate safe practices when smoking outside as evidenced by no unsafe behavior or injury related to smoking. Interventions included to encourage Resident #356 to communicate when going out to smoke, review smoking safety quarterly and as needed and observe for safe practice when smoking.

A Leave of Absence/Release from Responsibility Form for Resident #356 was reviewed. The form indicated " ... the resident is leaving, accepts complete responsibility for [themselves] while away from the center, and absolves the center, its management, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is away." The form included areas for the resident to date, time and sign in and out of the facility. Multiple entries were observed for Resident #356.

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An observation was made of the facility parking lot on 4/30/19 at 9:10 AM. A no parking zone, indicated by yellow stripes painted on the pavement, was noticed to have many cigarette butts discarded both on the pavement and in the grassy area located between the parking lot and the public sidewalk. Discarded cigarette butts were also observed in the pine straw mulch around the plants near the front door. No cigarette disposal containers were observed in these areas.

On 4/30/19 at 10:21 AM an interview with Resident #356 was conducted. He stated he had just been admitted and had no problems or concerns regarding his short time in the facility. He stated he was able to do most things independently.

On 4/30/19 at 10:27 AM Resident #356 had been observed standing in the facility parking lot, in the no parking zone, smoking. When he finished his cigarette, he extinguished the cigarette butt on the pavement and left the butt.

On 5/1/19 at 1:22 PM Resident #356 had been observed standing in the facility parking lot, in the no parking zone, smoking.

During an interview with the Administrator (AD) on 5/01/19 at 3:00 PM, he stated this was no-smoking facility. The AD indicated there was a smoking policy in the admission packet that the new residents would read it and sign prior to admission. The AD stated that all new residents were assessed for smoking. Residents who were alert, oriented, capable of signing themselves in and out of the facility, and assessed as safe

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smokers, were allowed to go outside and smoke. All smoking materials were kept locked in the medication carts, and the nurse would provide them to the resident when requested. The AD also stated, based on the location of the building, residents would go to the bus stop to smoke. He stated people who were waiting for the bus would smoke and he had no control over that. The AD stated when it was hot, cold or rainy weather, people waiting for the bus would utilize the covered porch and sometimes smoke. He further stated he had no control over residents who were alert and oriented and would like to go out or who were assessed as safe smokers. The AD stated residents were not monitored in the evening or night when going outside to smoke. He stated as the facility was a no-smoking facility, the staff did not monitor the smoking residents. The AD stated he would check people at various times and remind them that this was a smoke-free facility. The AD also stated there were no ash trays or sand buckets for the cigarette butts in front of the building as this would encourage residents to smoke.

On 5/02/19 at 12:50 PM an interview with Nurse #1 was conducted. The nurse stated Resident #356 was alert, oriented, could make his needs known and was ambulatory without an assistive device. Resident #356 had been assessed as safe to smoke and would sign himself out to smoke.

On 5/02/19 at 10:35 AM a follow up interview with the AD was conducted. He stated the no parking zone area was on the facility property. The AD further stated there were currently no smoking residents in the facility who had been "grandfathered" in when the no smoking policy

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F 689	Continued From page 28 had been put into effect. The AD stated upon admission the smoking policy is explained and they are told that they must stay off of the facility property to smoke. He stated the smokers seem to end up in that part of the parking area and were non-compliant with the smoking rule. He further stated he would expect the residents to follow the rules and for staff to enforce the rules and policies.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		5/28/19

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F 761	Continued From page 29 by: Based on observations and staff interviews the facility failed to remove one expired container of Vitamin B1, one expired insulin pen injector, failed to provide the date of opening for one insulin multi dose vial, stored in 3 of 6 medication administration carts (100 hall and 300 hall). Findings included: 1. On 4/30/19 at 9:10 AM, observation of the medication administration cart on 300 short hall, with Nurse #3, revealed opened medication Novolin (insulin) multi dose vial, 100 units/ml (milliliter), 10 ml, with no date of opening. On 4/30/19 at 9:15 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to mark the date of opening on the multi dose vial of insulin and remove expired medications from the medication administration cart. The nurse confirmed that the insulin was opened but she did not use this medication during her shift. The nurse had not checked the insulin multi dose vial in her medication administration cart at the beginning of her shift. 2.On 4/30/19 at 9:30 AM, observation of the medication administration cart on 300 long hall, with Nurse #4, revealed one container of Vitamin B1, 50 mg (milligram), 100 tablets, expired in June 2018. On 4/30/19 at 9:35 AM, during an interview, Nurse #4 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that she	F 761	Corrective action the resident found to have been affected by the deficient practice: All residents are affected. On 5/3/2019, all 6 medication carts were checked/audited by the Director of Health Services, Unit Managers and the Clinical Competency Coordinator. Any expired and undated and undated medications were removed and returned to the pharmacy per policy. Corrective action for other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. On 5/3/2019, all 6 medication carts were checked/audited by the Director of Health Services, Unit Managers and the Clinical Competency Coordinator. Any expired and undated and undated medications were removed and returned to the pharmacy per policy. Systemic changes made to ensure that the deficient practice will not recur: On 5/6/2019, the Clinical Competency Coordinator and the Director of Health Services educating the Licensed Nurses on Labeling/Storage of Drugs and Biologicals. All licensed nurses will be educated by 5/25/2019. The licensed nurses will review their assigned medication rooms and medication carts for unlabeled medications and Biologics as well as expired medications and	

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F 761	Continued From page 30 did not use this medication during her shift. The nurse had not checked the expiration dates in her medication administration cart at the beginning of her shift. 3.On 4/30/19 at 9:50 AM, observation of the medication administration cart on 100 long hall, with Nurse #1, revealed one expired Novolog (insulin) Flex Pen, 100 units/ml, 3 ml. Per the label on the insulin pen, it was opened on 3/28/19. Review of the manufacturer ' s literature/information (or package insert) recommended to discard the Novolog Flex Pen 28 days after opening, which would have been on 4/25/19. On 4/30/19 at 9:55 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that the insulin pen was expired. The nurse had not check the expiration date on Novolog Flex Pen in his medication administration cart at the beginning of the shift. On 5/2/19 at 2:55 PM, during an interview, the Director of Nursing indicated that all the nurses were responsible to put date of opening on insulin pens and multi dose vials, check all the medications in medication administration carts for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.	F 761	Biologics daily for 7 days then weekly thereafter. The licensed nurse review will be given to the Director of Health Services to validate the removal of all expired and/or unlabeled medications and biologics. The Consultant Pharmacist will review the medication rooms and medication carts for expired and/or unlabeled medications and biologics monthly. Plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or Nurse Mangers will validate the License Nurse review of the Medication rooms and medication carts daily for 7 days then weekly thereafter for 4 weeks then monthly thereafter. The Consultant Pharmacist will review the medication rooms and medication carts for expired and/or unlabeled medications and biologics monthly. The Director of Health Services will present an analysis of their review to the Quality Assurance Performance Improvement committee monthly until 3 consecutive months of compliance is sustained then quarterly. Date of Compliance: 5/28/2019	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		5/28/19

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F 867	Continued From page 31 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in March 2018 and subsequently recited in May 2019 on the current recertification survey. The recited deficiency was in the area of develop a quarterly Minimum Data Set assessment at least every 3 months. The deficiency was recited in the current recertification survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: The tag was cross referenced to: F 638 - Quarterly assessments at least every 3 months. Based on record review and staff interviews, the facility failed to complete a quarterly assessment for 1 of 24 residents who had Minimum Data Set (MDS) assessments reviewed (Resident #355). During the previous recertification survey on 3/29/18 the facility failed to complete a quarterly MDS assessment within 92 days of the previous MDS assessment for 2 of 6 residents (Resident	F 867	Corrective action the resident found to have been affected by the deficient practice: Resident #355 still resides in the facility. The quarterly assessment was completed on 5/2/2019 by the MDS Director. Corrective action for other residents having the potential to be affected by the same deficient practice: The Administrator and the Director of Health Services educated on the Quality Assurance and Performance Improvement policy/process for members of the QA Committee with emphasis on identifying areas that may lead to deficiency practice. Education will be completed by 5/25/2019. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on ensuring that any areas on non-compliance are addressed to prevent further deficient practices related completing quarterly MDS assessment. At least a member of the regional team that includes senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for 3 quarters. Systemic changes made to ensure that	

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F 867	Continued From page 32 #10 and Resident # 359) reviewed. During an interview on 5/2/19 at 6:50 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress. The Administrator stated any deficient practice identified was addressed in the QAPI and the time line for monitoring was based on the severity of the deficiency. The monitoring tools were used for tracking the outcomes, and improvements and training to staff were done accordingly.	F 867	the deficient practice will not recur: The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Tag F638 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter.The Quality Assurance and Performance Improvement committee will meet monthly to review the tracking and trending analysis of areas that led to a repeat tag/deficiency. The facility will develop a retrospective plan to examine facility standards and ensure no repeat citations. Plans to monitor its performance to make sure that solutions are sustained: Administrator will lead Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have led to repeated deficiency (Tag F638). This will ensure the facility is identifying areas on non-compliance and addressing them as needed to prevent further deficient practice related to Quarterly MDS assessments. A member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or Area Vice President will attend QAPI meetings for the next 3 months and then quarterly for 3 quarters to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and	

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F 867	Continued From page 33	F 867	then quarterly and/or as needed for 3 quarters for further recommendations until compliance is sustained. Date of Compliance: 5/28/2019	
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		5/28/19

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F 880	Continued From page 34 (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 observation, record review and staff interviews, the facility failed to prevent cross contamination of scissors and black marker by not cleaning them after use to cut gauze and date	F 880	Corrective action the resident found to have been affected by the deficient practice:	

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	345061	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 on a wound dressing during the wound treatment procedure for 1 of 2 residents, Resident #96. Findings included: Resident #96 was admitted to the facility on 6/29/18. Review of his recent Quarterly Minimum Data Set assessment, dated 4/16/19, revealed the resident had severe impaired cognition. Resident 96 ' s diagnoses included pressure ulcers, chronic right foot osteomyelitis (bone infection), and moderate protein-calorie malnutrition. The resident required total assistance with activities of daily living, received indwelling urinary catheter and was always incontinent for bowel. Resident 96 ' s plan of care, dated 4/23/19, reflected his potential and actual skin integrity issues, compromised healing process of resident ' s wounds, due to multiple diseases and conditions with appropriate goals and interventions. On 5/1/19 at 10:10 AM, an observation was conducted of pressure ulcer treatment for Resident #96, provided by Nurse #5, wound treatment nurse and Nurse #6. There were three pressure ulcers noted: stage IV pressure ulcer on the right heel, unstageable pressure ulcer on the left lateral foot, and stage II pressure ulcer on the sacral area. a.During the treatment of the right heel and left lateral foot wounds, Nurse #5 washed her hands and donned clean gloves to remove the old dressing. After she removed the old dressing, the nurse removed the gloves, washed her hands and donned clean gloves to apply medication to	F 880	Resident # 96 still resides in the facility. On 5/3/2019, Nurse #5 was educated on cross contamination. On 5/6/2019, nurse #5 was observed doing wound dressing on resident #96 by the Director of Health Services to ensure no cross contamination. Corrective action for other residents having the potential to be affected by the same deficient practice: On 5/6/2019, the Director of Health Services (DHS), Unit Managers, the Clinical Competency Coordinator and the Treatment Nurse reviewed all residents with wounds using the weekly wound report to ensure treatments were being done as ordered by the physician. On 5/3/2019, Nurse #5 was educated on cross contamination during wound dressing change. On 5/6/2019, education was initiated by the DHS and the Clinical Competency Coordinator for all licensed nurses on cross contamination during wound dressing changes to ensure no cross contamination for all other residents with wounds. Systemic changes made to ensure that the deficient practice will not recur: On 5/6/2019, the Director of Health Services (DHS), Unit Managers, the Clinical Competency Coordinator and the Treatment Nurse reviewed all residents with wounds using the weekly wound report to ensure treatments were being done as ordered by the physician. On	

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F 880	Continued From page 36 the wounds. After applying the medication, the nurse was observed removing the gloves, washing her hands and donning clean gloves to apply the new dressing. After the nurse applied the new dressing, Nurse #5 reached her right pocket, pulled out the scissors, and cut the extra gauze from the dressing on the right heel and left foot, and put the scissors back in her pocket. b.During the treatment of the sacrum wound, Nurse #5 washed her hands and donned clean gloves to remove the old dressing. After she removed the old dressing, the nurse removed the gloves and donned clean gloves, without washing her hands, to apply medication to the wounds. After applying the medication, the nurse was observed removing the gloves, washing her hands and donning clean gloves to apply the new dressing. After the nurse applied the new dressing, Nurse #5 reached her right pocket, pulled out the black marker, wrote the date on dressing and placed the marker back. On 5/1/19 at 4:30 PM, during an interview, Nurse #5 indicated that she followed the clean technique in wound treatment, as well as infection control policy and used personal protective equipment. She was aware that it is required to wash her hands between changing gloves during the procedure of wound treatment. The nurse confirmed that it is not appropriate to touch the scissors or highlighter in her pocket with contaminated gloves. On 5/2/19 at 2:35 PM, during an interview, Nurse #7, infection control nurse, confirmed that the staff must wash hands prior to use clean gloves, regardless of performing procedure. She indicated that she provided mandatory infection	F 880	5/3/2019, Nurse #5 was educated on cross contamination during wound dressing change. On 5/6/2019, education for other nurses (charge nurses and Unit Managers/Supervisors) was initiated by the DHS and the Clinical Competency Coordinator for all licensed nurses on cross contamination during wound dressing changes. The education will be completed by 5/25/2019. Charge Nurses, Unit Managers/Supervisors who have not completed the education will not be allowed to work until they are educated. All newly hired charge nurses, Unit Managers/Supervisors will be educated on cross contamination during wound dressing changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. The Director of Health Services and/or the Clinical Competency Coordinator will observe the nurses perform a return a return demonstration. Plans to monitor its performance to make sure that solutions are sustained; The Director of Health Services and the Clinical Competency Coordinator will observe treatment nurses daily for 5 days, then weekly for 4 weeks and, then monthly until 6 consecutive months of compliance are sustained. The Director of Health Services will report any areas of non-compliance to the Quality Assurance and Performance Improvement committee monthly for further recommendations until 6 consecutive months of compliance are sustained.	

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F 880	Continued From page 37 control training at orientation, annually, plus individual reeducation as needed. The nurse explained that in January 2019, all the employees demonstrated the skills, according to checklist, including clean technique and proper hand hygiene. On 5/2/19 at 2:55 PM, during an interview, the Director of Nursing expected the staff to follow infection control policy, implement clean technique, when applicable and appropriate hand hygiene.	F 880	Date of Compliance: 5/28/2019	