| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted from 5/28/19 through 5/30/19. The facility was in compliance with the requirement CFR483.73, Emergency Preparedness. See Event # 6WMX11. | E 000 | | |
| F 640 SS=D | Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§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:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, 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.<br><br>§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: | F 640 | | 6/21/19 |

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

Electronically Signed | 06/16/2019

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| F 640 | Continued From page 1<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete and transmit a death in facility tracker Minimum Data Set (MDS) assessment within the required time frame for 1 of 3 residents reviewed for submission of MDS assessments (Resident #1).<br>Findings included:<br><br>Resident #1 had been admitted on 2/27/17. His diagnoses included Parkinson's disease, major depressive disorder, chronic pain syndrome, and chronic obstructive pulmonary disease.<br><br>Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) was dated 1/23/19 and indicated he had received Hospice services.<br><br>Nursing documentation dated 3/5/19 at 7:07 AM indicated Resident #1 had expired in his room at | F 640 | This POC demonstrates Penick Village's written allegation of compliance for the listed deficiencies. However, submission of this POC is not an admission of an accurate deficiency citing. This timely POC submission is to uphold requirements according to state and federal law<br>.<br>F640 Encoding/Transmitting Resident Assessment<br><br>1. Record review showed that the Death in Facility Tracker had not been transmitted in the required timeframe for Resident #1. MDS Coordinator made the correction on 5/29/2019 for Resident #1.<br>2. This error could affect all MDS submissions for any death in facility not | |

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| F 640 | Continued From page 2<br>6:45 AM. Hospice and the physician had been notified.<br><br>On 5/29/19 at 4:18 PM an interview with MDS nurse #1 was conducted. The nurse stated a death in the facility tracker should have been completed within seven days. The nurse stated she was unsure how this had been missed.<br><br>On 5/30/19 at 10:24 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she would expect assessments to be completed per the MDS guidelines. | F 640 | reported within seven days of resident death.<br>3. Audit was conducted by the MDS Coordinator for all deaths in facility since 1/1/2019 to 6/14/2019. All deaths were reported. Upon completion of the audit on 6/14/19, the MDS Coordinator reported the findings to the Administrator that there were no unreported deaths from 1/1/19-6/14/19. These results will also be shared in the June Quality Assurance/Quality Assurance & Performance Improvement (QA/QAPI) Meeting.<br>4. The MDS Coordinator will also attend a training workshop offered by the NC DHSR in Raleigh in September 2019.<br>4. The Director of Nursing (DON) will audit Death in facility Tracker for the next three months as deaths occur, and the DON will report findings in QA/QAPI at the end of those three months (8/2019). | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Activities of Daily Living (ADLs) (Residents #13 and #22) and restraints (Resident #13 and #22) for 2 of 14 residents reviewed.<br>The findings included:<br><br>1.a. Resident #13 had been readmitted on | F 641 | F641 Accuracy of Assessments<br><br>1. Inaccuracy in assessments was found in Residents #13 & 22 for Activities of Daily Living and Restraints due to MDS Coordinator being taught that overriding Nursing Assistants□ coding with factual information was not allowed. The MDS Coordinator made a Significant Correction | 6/16/19 |

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| F 641 | Continued From page 3<br>1/24/18. Her diagnoses included diabetes, end stage renal disease, and left above the knee amputation.<br><br>Resident' #13's Annual Minimum Data Set (MDS) dated 12/28/18 indicated she was cognitively intact. She was independent with bathing and required supervision assistance with locomotion on the unit and toileting. She was noted as continent of bowel.<br><br>Resident #13's Quarterly MDS assessment dated 3/28/19 indicated she was cognitively intact. She required total assistance with bathing and required extensive assistance with locomotion on the unit and toileting. Her bowel continence was not rated, indicating she had an ostomy, or no bowel movement for the entire seven day look back period.<br><br>Care plans most recently updated on 4/26/19 indicated she required total assistance with bathing, supervision assistance with locomotion via electric scooter and toileting.<br><br>On 5/28/19 at 2:03 PM Resident #13 was observed sitting at her bedside, clean, groomed, and without odors. She was using a lap top and a cell phone.<br><br>On 5/28/19 at 4:04 PM Resident #13 was observed sitting at her bedside, clean, dressed and groomed, no odors. She stated she had recently finished bathing. She was using a lap top and a cell phone.<br><br>On 5/29/19 at 10:14 AM Resident #13 was observed watering plants in the lobby. She was sitting up in her power chair, maneuvering herself | F 641 | to Prior Quarterly Assessment for Resident #13 with an ARD of 5/30/2019, and a Significant Correction to Prior Quarterly Assessment for Resident #22 was initiated with an ARD of 6/12/19.<br>2. The MDS Coordinator was instructed by state surveyors on 5/29/2019 that coding for restraints should be coded as bedrails for mobility if the assessment supported their use. The MDS Coordinator verified this information through the MDS network and blogs that she utilizes. She was also instructed by state surveyors on 5/29/19 that factual changes can be made to inaccurate Nursing Assistant (NA) Activities of Daily Living (ADL) coding.<br>3. A new Philosophy and Process will be written by the Clinical Team (which consists of: the Administrator, Director of Nursing, Clinical Managers, Social Worker and Director of Rehab.) addressing the look back period, corrections and timeframe of MDS ADL Coding by 6/28/19. For further training & education, the MDS Coordinator will attend the NC DHSR workshop for coding in September 2019.<br>4. Weekly audits will be conducted by the Director of Nursing for two months on a random sample of no less than five, no more than 10 day shift and night shift of ADL function for comparison to factual ADL resident performance. In the event inaccurate NC coding is found, individual education will be performed based on audit findings by one of the Clinical Team members.<br>5. The audit results will also be shared | |

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| F 641 | Continued From page 4<br>in the chair without difficulty. She appeared clean, groomed, dressed and without odors.<br><br>On 5/29/19 at 10:45 AM an interview with Resident #13 was conducted. The Resident stated after bedside bath set up, she was able to wash herself. She also stated that twice a week she would shower, and the Nurse Aides (NAs) would help her, everyone washing different areas to quicken the showering process. Resident #13 also stated she had regular bowel movements.<br><br>On 5/29/19 at 3:42 PM an interview with MDS Nurse #1 was conducted. The nurse stated Resident #13 had not had a significant change in her status between December 2018 and March 2019. The nurse explained the coding for bathing, locomotion and toileting populated from the Nurse Aid documentation. She stated she had been unaware that she could override the NA coding with factual information.<br><br>0n 5/30/19 at 10:24 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she would expect the MDS to be coded accurately and reflect the condition of the resident.<br><br>1b. Resident #13 had been readmitted on 1/24/18. Her diagnoses included diabetes, end stage renal disease, and left above the knee amputation.<br><br>Resident #13's Quarterly MDS assessment dated 3/28/19 indicated she was cognitively intact. She required supervision with bed mobility. Bed side rails had been noted as used daily as a restraint.<br><br>A physical restraint care plan had been initiated | F 641 | by the DON in the Quality Assurance/Quality Assurance & Performance Improvement meetings for the next 12 months. | |

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| F 641 | Continued From page 5 | F 641 | | |

on 5/28/19. The care plan indicated Resident #13 used bed side rails to promote bed mobility. The care plan also noted she was able to move independently in bed.

On 5/28/19 at 2:03 PM Resident #13 was observed sitting on the side of her bed. She was using a lap top and a cell phone. Bilateral quarter length bedside rails were observed in the up position. The rails were not restricting her movement.

On 5/28/19 at 4:04 PM Resident #13 was observed sitting on the side of her bed. She stated she had recently finished bathing. She was using a lap top and a cell phone. Bilateral quarter length bedside rails were observed in the up position. The rails were not restricting her movement.

On 5/29/19 at 10:14 AM Resident #13 was observed watering plants in the lobby. She was sitting up in her power chair, maneuvering herself in the chair without difficulty.

On 5/29/19 at 10:45 AM an interview with Resident #13 conducted. The Resident stated she used the bed side rails to assist her to turn and position and to sit up on the side of the bed. Resident #13 was able to demonstrate at that time how the rails assisted her with bed mobility and sitting up on the side of the bed.

On 5/29/19 at 3:42 PM an interview with MDS Nurse #1 was conducted. The nurse stated Resident #13 was alert, oriented and able to make her needs known. The nurse stated Resident #13 was able to use the bed side rails to assist her with bed mobility and to sit up on the

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| F 641 | Continued From page 6 | F 641 | | |

side of the bed, and the rails did not restrict her movement or access to her body. The nurse stated Resident #13's bed side rail use did not fit the definition of a restraint.

05/30/19 at 10:24 AM an interview with the Director of Nursing (DON) was conducted. The DON stated she would expect the MDS to be coded accurately and reflect the condition of the resident.

2a) Resident #22 was originally admitted to the facility on 10/30/14 with a readmission date of 3/29/19. The diagnoses included congestive heart failure, anemia, history of a right hip fracture and dementia.

A review of the daily charting detail for Activities of Daily Living (ADL's) from 3/30/19 to 4/5/19 revealed the areas of dressing and bathing were not coded.

A review of the nursing documentation dated 3/29/19 and 4/27/19 noted the resident performed ADL tasks with assistance of one person.

The most recent Minimum Data Set (MDS) coded as a Significant Change assessment and dated 4/5/19, assessed the resident as cognitively intact. She was coded as requiring setup assistance with meals, supervision for toileting and personal hygiene and limited assistance for bed mobility. The dressing task was coded with dashes for both self-performance and support provided by staff and the bathing section was coded as the activity did not occur during the seven day look back period.

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Home Care Sitter #1 was interviewed on 5/29/19 at 1:05pm. She indicated the facility staff assisted with Resident #22's ADL's. She was able to state the resident had been observed to remove and replace gowns with assistance to fasten and was able to sponge bathe herself after setup assistance from the nursing staff.

On 5/29/19 at 1:15pm an interview occurred with Nursing Aide (NA) #1. She stated the resident was able to remove her gown and replace it with fastener assistance. She added Resident #22 preferred to sponge bathe on the side of her bed and was able to do so either with moistened bathing cloths or setup of supplies by the staff. She stated the nursing staff were expected to provide assistance with Resident #22's ADL's even when the Home Care sitter was present.

An interview was conducted with the MDS Nurse on 5/29/19 at 3:27pm. She confirmed the dressing portion of the MDS assessment dated 4/5/19 was marked with dashes and the bathing section was marked with eights (activity did not occur). She explained that she coded the ADL portion of the assessment based on the ADL charting detail completed by the NA's. She explained she went and observed and interviewed the resident as well as reviewed the medical record for staff documentation, but she only coded per the ADL form completed by the NA's. She added the resident had private sitters that also helped with her care and she could not code for that. The MDS nurse added she was aware Resident #22 could complete most of her ADL's with setup to limited assistance. The MDS nurse further explained the sitters were employs of the Home Care division of the company and she didn't consider them facility employees;

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therefore, she had not interviewed them as to the resident's ability to complete ADL's.

On 5/30/19 at 8:30am the resident was observed sitting on the side of her bed. She was able to demonstrate washing herself with a body cloth without difficulty. She stated that she preferred to do this herself, however the staff would setup a pan of water and gather the supplies for her when requested. She demonstrated putting on and removing a gown with assistance needed to fasten. The resident stated she preferred to wear hospital gowns.

Home Care sitter #2 was interviewed on 5/30/19 at 8:35am. She indicated the nursing staff assisted with Resident #22's ADL's as she was there for company and to assist or obtain assistance with the resident's requests. She confirmed the resident was able to dress herself with fastener assistance and sponge bathe herself after setup assistance.

On 5/30/19 at 10:40am an interviewed occurred with NA #2. She stated Resident #22 preferred to wear hospital gowns but was able to remove and replace with fastener assistance only and preferred to sponge bathe while sitting in her bed.

An interview occurred with the Director of Nursing on 5/30/19 at 10:20am and confirmed the Home Care Sitters were employees of the company. She further stated it was her expectation for the MDS to be coded accurately.

An interview was conducted with the Administrator on 5/30/19 at 11:10am and confirmed the Home Care sitters were employees of the company. She further stated it was her

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expectation for the MDS to be coded accurately.

2b) Resident #22 was originally admitted to the facility on 10/30/14 with a readmission date of 3/29/19. The diagnoses included congestive heart failure, anemia, history of a right hip fracture and dementia.

Review of the medical record revealed an order dated 4/4/19 for the use of half side rails to promote bed mobility.

The most recent Minimum Data Set (MDS) coded as a Significant Change assessment and dated 4/5/19, assessed the resident as cognitively intact. She was coded as requiring setup assistance with meals, supervision for toileting and personal hygiene and limited assistance for bed mobility. Limited range of motion present to one lower extremity. Bed rails were marked as physical restraints used daily.

Review of the Physical Restraint Care Area Assessment (CAA) Analysis dated 4/10/19 revealed the area triggered due to the resident using half side rails to promote bed mobility as ordered by the physician.

Review of the active care plan dated 4/10/19 revealed a problem area of physical restraints due to the resident using half upper side rails to the bed to promote bed mobility per physician order.

Resident #22 was observed on 5/29/19 at 8:35am using the bed rails to reposition herself in the bed. She added that she also used them to sit up to the side of the bed.

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Home Care Sitter #1 was interviewed on 5/29/19 at 1:05pm. She confirmed the resident was able to use the bed rails to turn and reposition self as well as to sit up to the side of the bed. She added the bed rails did not interfere with the resident's mobility.

On 5/29/19 at 1:15pm an interview occurred with Nursing Aide (NA) #1. She stated the resident preferred to stay in bed and was not able to walk or get up unassisted. She stated the resident used the bed rails to reposition herself in the bed as well as to sit up to the side of the bed. She added the bed rails did not impede the resident's ability to move her extremities.

An interview was conducted with the MDS Nurse on 5/29/19 at 3:27pm. She stated Resident #22 was no longer getting out of bed and preferred to use the bed rails to turn and reposition self. She added a consultant had told her that any resident ordered with a bed rail should be marked as a restraint on the MDS. She acknowledged Resident #22 used the bed rails as an enabler for independent bed mobility.

On 5/30/19 at 8:30am the resident was observed sitting on the side of her bed. She was able to demonstrate lying back in the bed by swinging her legs around and onto the bed as well as holding the bed rails for support. She was then observed to use the bed rails for turning and repositioning as well as to sit back up to the side of the bed. The resident was able to recall her recent readmission from the hospital in March 2019 and stated that she had always used the bed rails for support and assistance as she wanted to do all she could for herself.

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| F 641 | Continued From page 11<br>Home Care sitter #2 was interviewed on 5/30/19 at 8:35am. She stated the resident used the bed rails to turn and reposition herself as well as to sit up to the side of the bed. She added the bed rails did not interfere with the resident's movement or mobility.<br><br>The Medical Director was interviewed on 5/30/19 at 10:10am. He stated the bed rail use for Resident #22 was intended as an enabler for independent bed mobility and not a restraint.<br><br>On 5/30/19 at 10:40am an interview occurred with NA #2. She stated the resident used the bed rails to reposition herself in the bed as well as to sit up to the side of the bed. She added the bed rails did not restrict the resident's movement or mobility.<br><br>An interview occurred with the Director of Nursing on 5/30/19 at 10:20am. She stated her expectations were for the MDS to be coded accurately.<br><br>On 5/30/19 at 11:10am the Administrator was interviewed and stated it was her expectation for the MDS to be coded accurately. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive | F 656 | | 6/16/19 |

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| F 656 | Continued From page 12<br>assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview of the resident and staff, the facility failed to develop a comprehensive care plan for range of motion and contracture prevention for 2 of 4 residents reviewed for mobility (Residents #24 and #31). Findings included: | F 656 | F656 Develop/Implement Comprehensive Care Plan<br><br>1. Comprehensive Care Plans for Residents #24 & 31 were reviewed and updated by the MDS Coordinator on | |

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| F 656 | Continued From page 13<br><br>1. Resident #24 was admitted to the facility on 3/1/16 with diagnoses of Multiple Sclerosis (MS), neuromuscular dysfunction of the bladder, contracture of muscle unspecified site, and chronic pain syndrome.<br><br>A review of Resident #24's significant change Minimum Data Set (MDS) dated 4/18/19 revealed the resident had an intact cognition and was totally dependent on staff for all activities of daily living. The active diagnoses were MS, functional quadriplegia, and contracture of muscle unspecified site. The resident received scheduled and as needed pain medication. No therapy or restorative programs. The resident participated in her assessment.<br><br>A review of Resident #24's care plan dated 4/29/19 revealed a category for activities of daily living (ADL) function/rehab potential at risk for decline related to MS and functional quadriplegia and at risk for complications related to deficit in physical abilities. No intervention for range of motion or contracture prevention was identified.<br><br>On 5/28/19 at 4:10 pm an interview was conducted with Resident #24 who stated she had MS and contracture and had not received passive range of motion (PROM) services on a regular basis, only occasionally by some of the nursing assistant (NA)s and would like to regularly receive services to prevent further contractures and to provide pain relief.<br><br>On 5/29/19 at 11:10 am an interview was conducted with Nurse #4 who stated she | F 656 | 6/13/19. Physician□s orders were written for passive range of motion (PROM).<br>2. All residents not currently receiving therapy services could be impacted by this deficiency. Those residents will have their care plan reviewed by the Clinical Team to determine accuracy and necessity of therapy interventions for limited range of motions or decreased ability to perform Activities of Daily Living (ADL). Those identified will have a therapy consult by 6/28/19.<br>3. Therapy orders will be written for those residents found to be at risk and Passive Range of Motion (PROM) exercises will be added to Care Plan(s). Care plans will be updated to reflect any changes made.<br>4. MDS and therapy department will monitor all affected residents for change in ADL status. Any changes will be reflected in an updated care plan. This information will be reported by the MDS Coordinator in the QA/QAPI Meeting for the next six months. | |

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| F 656 | Continued From page 14 | F 656 | | |

expected the NA to complete PROM when the resident received am care or bed bath. Nurse #4 was not aware of any interventions in the NA care plan.

On 5/29/19 at 3:55 pm an interview was conducted with the MDS Coordinator who stated she was responsible for developing and updating the resident's care plan. The MDS Coordinator stated that she was aware that Resident #24 has had a recent decline, was now less active and spending more time in bed and that she had contractures (extremities). The resident did not have interventions in her care plan for PROM and contracture prevention.

On 5/30/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to evaluate the need for range of motion to prevent further contractures and to care plan accordingly.

2. Resident #31 was admitted to the facility on 1/30/19 with diagnoses of dementia with Lewy bodies, debility, severe protein calorie malnutrition, and cognitive communication deficit.

A review of Resident #31's care plan dated 2/11/19 revealed no category, goals or interventions for contracture prevention or PROM.

A review or Resident #31's nursing assistant care plan did not have intervention to provide PROM.

A review of Resident #31's quarterly MDS dated 5/1/19 revealed the resident had no speech, was rarely or never understood. The resident had severely impaired cognition. The resident was

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| F 656 | Continued From page 15 | F 656 | | |

totally dependent for all ADLs. The active diagnoses were non-Alzheimer's dementia, malnutrition, and adult failure to thrive.

On 5/29/19 at 9:30 am an observation was done of Resident #31 receive pressure ulcer care to the base of her right great toe and sacrum by Nurse #4. The resident was undressed and was noted to have bilateral contracture to her knees and hips. The resident was non-verbal.

On 5/29/19 at 9:30 am an interview was conducted with Nurse #4 who stated Resident #31 was not receiving therapy or restorative services for PROM.

On 5/30/19 at 8:35 NA #10 was interviewed and stated that Resident #31 did not have the task of PROM on her NA care card. NA #10 commented that he straightened out the resident's extremities due to contractures when he dressed her but did not provide PROM. NA #10 stated that unless the resident had physical therapy, PROM would not be provided.

On 5/29/19 at 3:55 pm an interview was conducted with the MDS Coordinator who stated she was responsible for developing and updating the resident's care plan. The MDS Coordinator stated that she was aware that Resident #31 has had a recent decline, was now less active and spending more time in bed and that she had contractures (extremities). The resident did not have interventions in her care plan for PROM and contracture prevention.

On 5/30/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to evaluate the need for range

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| F 656 | Continued From page 16<br>of motion to prevent further contractures and provide services. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed revise the fall care plan for a discontinued intervention of a bedside floor mat for 1 (Resident #37) of 14 residents | F 657 | F657 Care Plan Timing and Revision<br><br>1. The fall care plan on for Resident #37 failed to show discontinuance of fall mat. | 6/16/19 |

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| F 657 | Continued From page 17<br>reviewed for care plan revision. The findings included:<br><br>Resident #37 was admitted 5/30/15 with his most recent readmission of 9/19/16 with cumulative diagnoses of Parkinson's Disease and Atrial Fibrillation.<br><br>Review of a Physician order dated 12/18/18 read to discontinue the bedside floor mat to the floor for Resident #37.<br><br>Review of Resident #37's most recent quarterly MDS dated 5/6/19 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for extensive assistance with bed mobility and total assistance with transfers. He was coded for physical impairment to his bilateral lower extremities. Resident #37 was coded as having no falls since the prior MDS assessment.<br><br>Review of Resident #37's fall care plan last revised 5/19/19 read he was at risk for falls related to balance problems, decreased safety awareness, Parkinson's Disease and a history of falls. Interventions included a bedside floor mat and staff were to ensure proper placement of the mat.<br><br>An observation on 5/28/19 at 10:09 AM revealed Resident #37 sitting up in a low bed. There was no bedside floor mat on the floor.<br><br>During a wound care observation on 5/29/19 at 9:00 AM, Nurse #1 stated Resident #37 had a bedside floor mat several months ago but it was discontinued She stated Resident #37 had not experienced any falls. | F 657 | Care Plan was revised by the MDS Coordinator to reflect the fall mat being discontinued as of 5/31/2019.<br>2. All current residents□ with fall mat orders were reviewed by the MDS Coordinator for care plan errors by 6/14/2019. No other care plan errors were found by MDS Coordinator□ review. The results were reported to the Administrator by the MDS Coordinator.<br>3. Interventions are entered upon each new fall. Fall Incidents are discussed in daily clinical meetings and weekly in the IDT meetings. Intervention orders or discontinuances are updated in the care plans as they occur. Monthly fall totals, their interventions and subsequent care plan updates will be discussed in Quality Assurance/Quality Assurance & Performance Improvement meetings by the Asst. Director of Nursing (DON)or DON for next 12 months. | |

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| F 657 | Continued From page 18 | F 657 | | |

In an observation on 5/30/19 at 8:45 AM, Resident #37 was sitting up in a low bed with no bedside floor mat on the floor.

In an interview on 5/30/19 at 8:50 AM, Nursing Assistant (NA) # 3 stated Resident #37 had not experienced any falls and she was not aware of the intervention of a bedside floor mat. NA #3 stated the use of the bedside fall mat must have been an old intervention that was discontinued.

During an interview on 5/30/19 at 9:55 AM, the MDS Nurse stated she reviewed and revised Resident #37's care plan on 5/19/19 after his quarterly MDS assessment of 5/6/19. She stated his bedside floor mat was discontinued back in December because he had not experienced any falls over a period. The MDS Nurse stated the possible explanation why she missed removing the bedside floor mat off the quarterly care plan review done in February 2019 was likely because of the conversion from one computer system to a new one on 1/29/19. The MDS Nurse stated she should have caught the bedside floor mat as a discontinued intervention and removed it from the care plan review done 5/19/19 but it was an oversight.

During an interview on 5/30/19 at 10:19 AM, the Director of Nursing stated it was her expectation that Resident #37's care plan be an accurate reflection of his fall interventions and she would have expected the bedside floor mat intervention to have been removed from his care plan.

During an interview on 5/30/19 at 11:00 AM, the Administrator stated it was her expectation that Resident #37's care plan be an accurate reflection of his fall interventions and she would

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| F 657 | Continued From page 19<br>have expected the bedside floor mat intervention to have been removed from his care plan. | F 657 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§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<br><br>§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.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interview of the resident and staff, the facility failed to provide care and services for range of motion and contracture prevention for 2 of 4 residents reviewed for mobility (Residents #24 and #31). Findings included:<br><br>1. Resident #24 was admitted to the facility on 3/1/16 with diagnoses of Multiple Sclerosis (MS), neuromuscular dysfunction of the bladder, contracture of muscle unspecified site, and chronic pain syndrome. | F 688 | F688 Increase/Prevent Decrease in ROM/Mobility<br><br>1. The development of a Passive Range of Motion (PROM)and Contracture Prevention Care Plan was not completed for Residents #24 & 31. Care Plans were reviewed/updated by 6/14/2019 by MDS Coordinator. The residents affected will have PROM performed twice daily with a.m. and p.m. care. The completed updates were then reported to the Administrator. The care plan and their | 6/28/19 |

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| F 688 | Continued From page 20<br>A review of Resident #24's significant change Minimum Data Set (MDS) dated 4/18/19 revealed the resident had an intact cognition and was totally dependent on staff for all activities of daily living. The active diagnoses were MS, functional quadriplegia, and contracture of muscle unspecified site. The resident received scheduled and as needed pain medication. No therapy or restorative programs were checked.<br><br>A review of Resident #24's care plan dated 4/29/19 revealed a category for activities of daily living (ADL) function/rehab potential at risk for decline related to MS and functional quadriplegia and at risk for complications related to deficit in physical abilities. No intervention for range of motion or contracture prevention was identified.<br><br>On 5/28/19 at 4:10 pm an interview was conducted with Resident #24 who stated she was informed by staff that if she could not make rehab progress, she could not have physical or occupational therapy services. The resident stated she was not making progress with therapy due to advancing MS. The resident commented she had not received passive range of motion (PROM) services on a regular basis, only occasionally by some of the nursing assistant (NA)s and would like to regularly receive services to prevent further contractures and to provide pain relief.<br><br>On 5/29/19 at 10:10 am an interview was conducted with Nurse #4 who stated Resident #24 was not receiving therapy services and the facility did not have nursing rehab services.<br><br>On 5/29/19 at 10:45 am a brief observation was | F 688 | updates are available for the Nursing Assistants to access. The care plans now indicate when PROM will be utilized during resident care.<br>2. The MDS Coordinator will provide a list of all residents that could potentially be impacted by this deficiency to the Rehab Dept. by 6/17/19. Residents identified will be evaluated by the Rehab. Department by 6/21/2019.<br>3. Those residents identified through the evaluations as being at-risk will have a therapy order written for PROM. MDS Coordinator will add this information to the resident□(s)' care plan by 6/28/19. Care Plans will reflect frequency of PROM to prevent contractures and loss of range of motion. Director of Rehab Services will give progress report in weekly Interdisciplinary Team Meetings for next 12 months.<br>4. MDS Coordinator will report quarterly care plan updates regarding therapy progress and at-risk status for ROM & contracture prevention in Quality Assurance/Quality Assurance & Performance Improvement every three months for next 12 months. | |

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done of Resident #24 who received a bed bath by NA #9. No PROM was completed during this time.

On 5/29/19 at 11:05 am an interview was conducted with Resident #24 who stated that she did not receive PROM by the NA during care this morning.

On 5/29/19 at 11:10 am an interview was conducted with Nurse #4 who stated she expected the NA to complete PROM when the resident received morning care or bed bath.

On 5/30/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to evaluate the need for range of motion to prevent further contractures and to provide services.

2. Resident #31 was admitted to the facility on 1/30/19 with diagnoses of dementia with Lewy bodies and cognitive communication deficit.

A review of Resident #31's care plan dated 2/11/19 revealed no category, goals or interventions for contracture prevention or PROM.

A review or Resident #31's nursing assistant care plan did not have intervention to provide PROM.

A review of Resident #31's quarterly MDS dated 5/1/19 revealed the resident had no speech, was rarely or never understood. The resident had a severely impaired cognition. The resident was totally dependent for all ADLs. The active diagnoses were non-Alzheimer's dementia, malnutrition, and adult failure to thrive.

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| F 688 | Continued From page 22<br>On 5/29/19 at 9:30 am an observation was done of Resident #31 receive pressure ulcer care to the base of her right great toe and sacrum by Nurse #4. The resident was undressed and was noted to have bilateral contracture to her knees and hips. The resident was non-verbal.<br><br>On 5/29/19 at 9:30 am an interview was conducted with Nurse #4 who stated the resident was not receiving therapy or restorative services for PROM.<br><br>On 5/30/19 at 8:35 NA #10 was interviewed and stated that Resident #31 did not have the task of PROM on her nursing care card. NA #10 commented that he straightened out the resident's extremities due to contractures when he dressed her but did not provide PROM. NA #10 stated that unless the resident had physical therapy, PROM would not be provided. NA #10 was aware of the resident's pressure ulcer on the base of her right big toe and agreed that it was most likely caused by the resident's folded legs pressing together. The resident held her legs bent at the hips and knees and they were pressed together increasing the chance of a pressure ulcer. NA #10 felt that PROM could help keep her legs moving and would be easier to dress.<br><br>On 5/30/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to evaluate the need for range of motion to prevent further contractures and provide services. | F 688 | | |
| F 700 SS=E | Bedrails<br>CFR(s): 483.25(n)(1)-(4) | F 700 | | 6/21/19 |

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| F 700 | Continued From page 23<br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and Physician interviews and record review, the facility failed to reassess and reevaluate for the continued need for side rails (Resident #37) and failed to complete a Side Rail assessment (Resident #22 and Resident #24). This was for 3 of 4 residents reviewed for bed rails. The findings included:<br><br>1. Resident #37 was admitted 5/30/15 with his most recent readmission of 9/19/16 with cumulative diagnoses of Parkinson's Disease and Atrial Fibrillation.<br><br>Review of the medical record reviewed the most recent Side Rail Assessment and Evaluation form | F 700 | F700 Bedrails<br><br>1. Observations and interviews determined that the facility failed to reassess and reevaluate for the continued use of bedrails for Resident #37, and also failed to complete a Side Rail Assessment for residents #22 & 24. Bed rail screen was completed on 6/11/2019 by the MDS Coordinator.<br>2. This deficiency could potentially impact any resident who still has bedrails installed to include Residents #37 and #24. Resident 22 received a new bed on 6/7/2019 without bedrails. Resident #37 | |

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| F 700 | Continued From page 24<br>was completed 9/20/16. This form indicated the ½ side rails were needed to serve as an enabler to promote independence and had expressed a desire to have the side rails raised while in bed. The form indicated a Physician order was obtained on 9/20/16 for the ½ side rails. The facility was unable to provide any additional information regarding the reassessment or reevaluation of the ½ side rails.<br><br>Review of the last fall incident for Resident #37 was 6/26/18 in the bathroom. The interventions were to reinforce staff to not leave Resident #37 unattended in the bathroom.<br><br>Resident #37's annual Minimum Data Set (MDS) dated 8/13/18 indicated moderate cognitive impairment and he exhibited no behaviors. Resident #37 was coded as requiring extensive assistance with bed mobility and transfers. He was coded for physical impairment to his bilateral lower extremities. Resident #37 was coded for 2 or more falls without injury. He was coded for a physical restraint due to presence of the side rails.<br><br>The Care Area Assessment (CAA) for Physical Restraints dated 8/13/18 read Resident #37 currently had side rails. The CAA read the facility had developed a policy to remove all side rails. There was no other documentation on the CAA.<br><br>Review of a care plan note dated 8/23/18 read Resident #37's RP was present. There was no documented evidence regarding a discussion about the reassessment for the continued need of the ½ side rails during the care plan meeting.<br><br>Review of a care plan note dated 11/14/18 read | F 700 | was reassessed and it was determined that the bedrails could pose a risk and were removed. Resident #24 received a complete reassessment. It was determined that the bedrails were not a restraint and were necessary for pillow positioning. Grab bars would not meet her needs and resident choice was noted.<br>3. A review of all remaining bedrails in the unit was conducted by the MDS Coordinator on June 10, 2019. Seven residents were identified to have bedrails remaining. Assessments were completed and reevaluations will be updated by 6/17/19. The bedrail Philosophy and Process will be reviewed by the Administrator by 6/21/19 to ensure that it properly reflects the intent of the regulation and the community□'s culture and belief in resident autonomy. The seven residents who could be impacted will be reassessed by June 21, 2019 by MDS Coordinator for their continued need and use; also keeping in mind the resident□s choice if alert and oriented. If it is determined through therapy department assessment that bed mobility is only feasible with bedrails, they will be replaced with grab bars. This change will be updated in the resident□(s)' care plan by 6/28/19.<br>4. To prevent this deficiency from impacting remaining residents with bedrails; bedrails deemed appropriate for bed mobility and left in place due to resident choice will be reassessed and reevaluated in conjunction with each quarterly MDS assessment date. Weekly tracking of remaining bedrails will be | |

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| F 700 | Continued From page 25<br>Resident #37's RP did not attend the meeting but there was no documented evidence regarding a discussion about the reassessment for the continued need of the ½ side rails during the care plan meeting.<br><br>Review of an incident report dated 2/6/19 indicated Resident #37 sustained a bruise to his right upper arm where he struck his arm on the side rail. The new intervention was to pad the ½ side rails.<br><br>Review of a care plan note dated 2/13/19 read Resident #37's RP was present. There was no documented evidence regarding a discussion about the reassessment for the continued need of the ½ side rails during the care plan meeting.<br><br>Review of Resident #37's most recent quarterly MDS dated 5/6/19 indicated severe cognitive impairment and he exhibited no behaviors. He was coded for extensive assistance with bed mobility and total assistance with transfers. Resident #37 was also coded for one stage two pressure ulcer. He was coded for physical impairment to his bilateral lower extremities. Resident #37 was coded as having no falls since the prior MDS assessment. He was coded for a physical restraint due to the presence of the side rails.<br><br>Review of Resident #37's physical restraint care plan last revised 5/19/19 read he required the use of ½ side rails to promote bed mobility per physician's order. Resident #37 was at risk for decreased mobility, falls and injury from the use of side rails. Interventions included the following: No complications from the use of the side rails through the next review, staff to monitor for the | F 700 | monitored by the Director of Nursing until all bedrails have been removed according to policy. All new admissions will be assessed by therapy department for need of mobility grab bars.<br>5. The Clinical Team was educated on when grab bars were to be implemented and when bedrails were to be removed entirely. Status updates for those potentially impacted will be given by the Director of Nursing at the regularly scheduled QA/QAPI Meetings for the next 12 months. | |

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continued need for the side rails and staff to observe for any signs or symptoms of complications with the side rail use.

During an observation on 05/28/19 at 10:09 AM revealed Resident #37 sitting up in a low bed with padded ½ side rails engaged. His right hand was noted to the down between the bed frame and the padded ½ side rail. When asked to lift his hand, Resident #37 did not comply. There was no visible evidence of injury to his right hand.

During an observation on 5/29/19 at 8:30 AM, Nursing Assistant (NA) #3 was observed sitting beside Resident #37's low bed assisting him with his breakfast. The padded ½ side rails were observed engaged. Resident #37's right hand was again observed resting between the bed frame and the padded ½ side rail. NA #3 stated he prefers to rest his hand down, but she was not aware of any injuries related to him resting his hand between the bed frame and padded ½ side rail. She stated she was uncertain why Resident #37's ½ side rails were padded or why he had side rails. NA #3 stated she was not aware of any falls or attempts to get out of bed unassisted.

During a wound care observation on 5/29/19 at 9:00 AM, Nurse #1 stated the pressure ulcer to Resident #37's sacrum had a history of healing and reopening. She stated Resident #37's RP visited daily and she insisted he be up in the wheelchair for several hours daily. During the wound care observation, Resident #37 was rolled onto his left side at which time he grabbed onto the padded ½ side rail and was held in position by Nurse #3. Nurse #1 stated Resident #37 does not move about in the bed and was not able to roll himself over independently with the use of the ½

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padded side rail. Nurse #1 stated the reason Resident #37's ½ side rails were padded was because he moved his arms and was known to beat his arms on the side rails due to his Parkinson's Disease.

In an interview on 5/29/19 at 1:30 PM, the Director of Nursing (DON) stated the reason Resident #37 had ½ padded side rails was because the RP refused the removal of the side rails. The DON stated the facility had recently developed the policy of removing all the side rails once a resident expires or was discharged. The DON stated it was her expectation as of 5/29/19 that the Side Rail Assessment and Evaluation be completed quarterly.

In an interview on 5/29/19 at 2:51 PM, the Assistant Director of Nursing (ADON) stated the facility practice was only to complete a Side Rail Assessment and Evaluation on admission and readmission. She stated the facility did not reassess or reevaluate for the continued need of side rails. The ADON stated the RP for Resident #37 wanted him to have the ½ padded side rails because of his fall risk.

In an interview on 5/29/19 at 3:40 PM, the MDS Nurse stated that according to the facility policy, all side rails were considered restraints. The MDS Nurse stated the Side Rail Assessment and Evaluation form was only completed on admission and readmission. She stated she was not aware how often a side rail or physical restraint reassessment and reevaluation was to be done. The MDS Nurse stated Resident #37's RP wanted him to have the side rails to prevent falls.

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In an observation on 5/30/19 at 8:45 AM, Resident #37 was sitting up in a low bed with bilateral padded ½ side rails engaged. His right hand was again observed hanging off the side of the bed between the bed frame and the padded side rail. There was no evidence of injury and Resident #37 would not lift his right hand on request.

In another interview on 5/30/19 at 8:50 AM, NA # 3 stated Resident #37 could use both arms and hands when he wanted too and was known to be combative at times during care. NA # 3 stated Resident #37 was not able to turn himself in the bed with the use of the side rail but once he was rolled over, he was able to hold onto the side rail to steady himself.

In a telephone interview on 5/30/19 at 10:10 AM, the Medical Director stated it was his expectation that side rails be reevaluated and reassessed periodically.

In an interview on 5/30/19 at 11:00 AM, the Administrator stated it was her expectation that Resident #37's side rails be reassessed and reevaluated periodically.

2) Resident #22 was originally admitted to the facility on 10/30/14 with a readmission date of 3/29/19. Her diagnoses included congestive heart failure, anemia, history of a right hip fracture and dementia.

Review of the unsigned side rail evaluation dated 2/24/19 revealed the resident desired side rails for the use of positioning or support with no risk to

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the resident when they are used. The staff did not complete the assessment in its entirety to include; the summary of findings and signature.

The most recent Minimum Data Set (MDS) coded as a significant change assessment and dated 4/5/19, assessed the resident as cognitively intact. She received setup to limited assistance for Activities of Daily Living (ADL's) and had impairment to one side of the lower body. The use of daily side rails was coded as a restraint.

Review of the resident's active care plan dated 4/10/19 revealed there was a problem area for the risk of falls, and ADL function with side rails mentioned as an intervention for enabling bed mobility.

On 5/29/19 at 8:35am the resident was observed using the side rails to reposition herself in the bed.

An interview was conducted with Nurse Aide (NA) #1 on 5/29/19 at 1:15pm. She stated the resident used the side rails to turn and reposition as well as to sit up to the side of the bed.

During an interview with the Assistant Director of Nursing (ADON) on 3/29/19 at 3:00pm, she stated the side rail assessments were completed on admission and readmissions. She reviewed the side rail evaluation dated 2/24/19 and confirmed the evaluation was incomplete.

On 5/30/19 at 8:45am an interview occurred with Nurse #2. He stated the resident used the side rails to reposition herself in the bed as well as to sit up to the side of the bed.

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An interview was completed with the Director of Nursing on 5/30/19 at 10:20am. She stated it was her expectation for the side rail evaluation to be completed accurately and completely.

On 5/30/19 at 11:10am an interview was conducted with the Administrator. She stated it was her expectation for the side rail evaluation to be completed accurately and completely.

3. Resident #24 was admitted to the facility on 3/1/16 with diagnoses of Multiple Sclerosis (MS), neuromuscular dysfunction of the bladder, contracture of muscle unspecified site, and chronic pain syndrome.

A review of Resident #24's significant change Minimum Data Set (MDS) dated 4/18/19 revealed the resident had an intact cognition and was totally dependent on staff for all activities of daily living. The active diagnoses were MS, functional quadriplegia, and contracture of muscle unspecified site. The resident participated in her assessment.

A review of Resident #24's care plan dated 4/29/19 revealed a category for one-half side rail use with interventions.

A review of the facility Residential Side Rail Utilization Policy dated October 2012 revealed the purpose was to ensure that side rail utilization is for the purpose of resident safety/security, repositioning assistance, and or proper positioning needs. The Side Rail Screening Tool will be completed in the electronic charting device.

A review of Resident #24's record from May 1,

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| F 700 | Continued From page 31 | F 700 | | |

2018 to present did not reveal a Side Rail Screen Tool was completed.

On 5/28/19 at 4:10 pm an interview was conducted with Resident #24 who stated she used her side rails to hold during turning and they were not restrictive.

On 5/29/19 at 10:10 am an interview was conducted with Nurse #4 who stated Resident #24 used her side rails. The resident cannot get out of bed on her own. Nurse #4 stated that staff nursing was not responsible for side rail assessment.

On 5/29/19 at 10:45 am an observation was done of Resident #24 who had one-half bilateral side rails and there was no gap between the rails and the mattress.

On 5/30/19 at 10:15 an interview was conducted with the physician who stated he expected staff to complete a side rail assessment before use and periodically for safety.

On 5/30/19 at 9:30 am an interview was conducted with the Assistant Director of Nursing (ADON) who stated that a side rail was completed for each resident on admission and readmit. The side rail assessment was not done quarterly. The ADON commented that there was no side rail policy. There was a restraint policy.

On 5/30/19 at 10:30 am an interview was conducted with the Director of Nursing who stated she expected staff to evaluate the need for and assess the safe use of side rails before use and

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| F 700 | Continued From page 32<br>at least quarterly. | F 700 | | |
| F 730 SS=E | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure Nursing Assistants (NA's) received annual Dementia training and Abuse/Neglect training. This was for 5 of 5 NA's reviewed for staffing. The findings included:<br><br>NA #4's date of hire was 8/31/15. Review of NA #4's Education/In-services records indicated no record of Dementia or Abuse/Neglect training since his hire date of 8/31/15.<br><br>NA #5's date of hire was 9/6/12. Review of NA #4's Education/In-services records indicated her last Abuse/Neglect training was 11/30/17 and no record of Dementia training since her hire date of 9/6/12.<br><br>NA #6's date of hire was 6/29/17. Review of NA #6's Education/In-services records indicated her last Abuse/Neglect training was 6/30/17. She was up to date of Dementia Training.<br><br>NA #7's date of hire was 11/26/12. Review of NA #7's Education/In-services records indicated her last Abuse/Neglect training was 9/24/17. She was | F 730 | F730 Nurse Aide Performance Review □ 12hr/yr. In-Service<br><br>1. It was determined by record review of five of five Nursing Assistants (NAs)did not meet the annual training requirement on dementia and/or Abuse/Neglect. The five identified were notified of their noncompliance and required to use Healthcare Academy module or be individually in-serviced by Director of Nursing (DON) or Administrator by 6/21/19.<br>2. All Healthcare residents have the potential to be affected by this deficiency. An education requirement audit of all currently employed Nursing Assistants was completed by the Human Resources Department by June 18, 2019 to determine any others who are not currently in compliance with abuse and dementia annual education requirements. All other NAs had met the requirement based on audit from Healthcare Academy completion records. | 6/21/19 |

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| F 730 | Continued From page 33<br>up to date of Dementia Training.<br><br>NA #8's date of hire was 08/04/05. Review of NA #8's Education/In-services records indicated her last Abuse/Neglect training was 11/30/17. She was up to date of Dementia Training.<br><br>During an interview on 5/29/19 at 1:30 PM, the Director of Nursing (DON) stated she started as a Clinical Manger in November 2018. She stated around that time, the previous Staff Development Coordinator (SDC) left employment. The DON stated she tried to stay on top of the staff training but she was also busy completing the Infection Control training and the staff training was not done. The DON stated she assumed the position of DON April of 2019 and to date, no new SDC had been hired. She stated it was her expectation that all employed aides receive annual Dementia training and annual Abuse/Neglect training.<br><br>During an interview on 5/30/19 at 11:00 AM, the Administrator stated it was her expectation that all employed aides receive annual Dementia training and annual Abuse/Neglect training. She stated when the previous SDC left last fall, the task of ensuring staff training did not get completed as expected. | F 730 | 3. The Director of Nursing and the Administrator will conduct six (three day shift & three night shift) In-Service Meetings to cover abuse and dementia annual training requirements to be in compliance by June 30, 2019. A module component and Healthcare Academy will also be available in lieu of in-person training. If NAs are unable to attend, they will be in-serviced by their charge nurse or on Healthcare Academy the first day they return to work. If this is not completed, they will not be scheduled again until they complete the requirement courses. This requirement applies to all full-time, part-time and prn statuses.<br>4. Dementia, Abuse/Neglect Training will continue to be given in all corporate orientations to all new hires. The month of June will become the annual All-Staff meeting that this same training will be presented. The first of these annual opportunities will be on June 20, 2019. Healthcare Academy will continue to serve as an online alternative to meet this requirement for those unable to participate in the training options in person. Signed In-Service sheets and monthly Healthcare Academy reports will be shared by the Director of Nursing in Quality Assurance/Quality Assurance & Performance Improvement Meetings for next 12 months. | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must - | F 812 | | 6/21/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

| (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 812 | Continued From page 34<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview of the staff, the facility failed to discard expired dry goods and date opened dry goods for 1 of 1 dry storage rooms observed. Findings included:<br><br>On 05/28/19 at 10:08 am the facility dry food storage was observed with the Dietary Manager (DM). The following food items stored were observed to have an expired date or were opened with no expiration date:<br><br>" Chocolate chips in storage container with label expiration dated 5/23/19;<br>" Carton of flour tortillas in manufacturer packaging expiration dated 4/27/19;<br>" Carton of flour tortillas in manufacturer packaging expiration dated 5/23/19;<br>" Graham cracker crumbs in manufacturers packaging that was opened and not expiration dated; | F 812 | F812 Food Procurement, Store/Prepare/Serve Sanitary<br><br>1. On 5/28/19, six items in the dry food storage of the North Kitchen were determined to either be expired or not dated according to regulatory requirements. The items identified were disposed of on 5/28/19 by the Dining Manager while surveyor present.<br>2. All Healthcare residents have the potential to be affected by this practice.<br>3. To ensure that this is not a widespread issue, all 219 boxes and 437 items in dry storage were checked for expiration, and all found to be labeled and within date range, therefore in compliance. This audit was conducted on June 10, 2019 by the Director of Dining Services. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | 05/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 812 | Continued From page 35<br>" Strawberry gelatin mix box was dated 9/18/19 as received and there was no expiration date; and<br>" Vanilla pudding mix box was dated 1/15/19 as received and there was no expiration date.<br><br>On 5/28/19 at 10:20 am an interview was conducted with the DM who stated she was responsible to daily check for expired food and drink items in dry storage. The DM stated that the items identified were expired and should have been discarded. The DM discarded the expired and undated items. The DM stated she did not discard the items as required.<br><br>On 5/30/19 at 11:00 am an interview was conducted with the Administrator who stated she expected the DM to daily check food and drink items for expiration and discard accordingly and to expire date all opened food and drink items. | F 812 | 4. To ensure that this noncompliance does not happen in the future, a weekly audit tool (Expiration Audit Log) for dry storage was created on June 9, 2019. The Kitchen/Dining Room Manager will compete weekly audits and report to the Director of Dining Services who will review the audit. Education for proper labeling of products in dry storage to include arrival date and expiration date was conducted with all dietary staff on June 3, June 5 and June 8 by the Kitchen/Dining Room Manager. In-service sheets were signed at each education session and given to the Administrator upon completion.<br>5. The results of the weekly Audit Log will be submitted for review to the Quality Assurance/Quality Assurance & Performance Improvement Committee monthly by the Director of Dining Services for the next 12 months. | |