

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/26/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 TANDAL PLACE KNIGHTDALE, NC 27545	
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E 000	Initial Comments An unannounced Recertification survey was conducted on 09/23/19 through 09/26/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9WI911.	E 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Annual Resident Review (PASARR) for 4 of 4 residents reviewed (Residents #12, #69, #34, and #37). Findings included: 1. Resident #12 was admitted to the facility on 5/15/15 with diagnoses which included diabetes and depression. The resident's medical record contained a PASARR Level II Determination Notification that was made on 6/24/15 with no end date. A review of the annual Minimum Data Set (MDS) assessment dated 3/20/19 indicated Resident #12 was not coded for Level II Preadmission Screening and Resident Review (PASARR) to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need,	F 641		10/24/19
			F <input type="checkbox"/> 641 ¿483.20(g) <input type="checkbox"/> Accuracies of assessments - The assessment must accurately reflect the resident's status. Corrective Action or the Resident Affected Regional MDS Coordinator modified residents, 12, 34, 37 and 69 for correcting their Preadmission Screening and Resident Review, (PASRR) to level 2 on the MDS Assessment, section A1500. The modifications were transmitted and accepted. Corrective Action for the Resident Potentially Affected On 09/25/19, the Regional MDS Coordinator and MDS Nurse reviewed the residents MDS for accurate information for Preadmission Screening and Resident Review (PASRR). Residents with inaccurate coding assessments relating to PASRR were modified and transmitted. Systemic Changes On 9/26/19 - The Regional MDS Coordinator provided in-service training to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/10/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	<p>Continued From page 1</p> <p>determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care.</p> <p>On 9/25/19 at 9:07 AM an interview was conducted with MDS Nurse #1 who stated the MDS assessment for Resident #12 dated 3/20/19 was incorrect and should have reflected her PASARR Level II status. She further stated she would submit a modification for the annual MDS assessment immediately.</p> <p>On 9/25/19 at 9:20 AM an interview was conducted with the Administrator who stated the facility had identified MDS assessments issues, but it had not been corrected yet.</p> <p>2. Resident #69 was admitted to the facility on 8/21/19 with diagnoses which included schizophrenia, anxiety and depression.</p> <p>The resident's medical record contained a PASARR Level II Determination Notification made on 10/17/18 with no end date.</p> <p>The admission Minimum Data Set (MDS) assessment dated 8/28/19 indicated Resident #69 was not coded for Level II Preadmission Screening and Resident Review (PASARR) to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting, and formulating a set of recommendations for services to help develop an individual's plan of care.</p> <p>On 9/25/19 at 9:07 AM an interview was</p>	F 641	<p>the inter-disciplinary team on Preadmission Screening and Resident Review (PASRR), including how to initiate the process, the agency responsible for issuance and approvals, uploading the PASRR information in the Electric Health Record, and notifying the MDS department of the PASRR along with the level.</p> <p>Quality Assurance The Executive Director, Business Office Manager and or the Director of Nursing will randomly monitor 3 PASRRs and ensure that they have been properly identified in Section A1500 utilizing the QA Monitoring Tool for PASRR identification, weekly for 12 weeks, then monthly using the QI Monitoring Tool for PASRRs. Opportunities to be corrected by the Social Worker and or MDS Coordinator as identified during the Quality monitoring. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and amend as needed.</p>		

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F 641	<p>Continued From page 2</p> <p>conducted with MDS Nurse #1 who stated the MDS assessment for Resident #69 dated 8/28/19 was incorrect and should have reflected his PASARR Level II status. She further stated she would submit a modification for the admission MDS assessment immediately.</p> <p>On 9/25/19 at 9:20 AM an interview was conducted with the Administrator who stated the facility had identified MDS assessments issues, but it had not been corrected yet.</p> <p>3. Resident #37 was admitted to the facility on 1/22/19. His active diagnoses included unspecified psychosis not due to a substance or known physiological condition.</p> <p>Resident #37's Preadmission Screening and Resident Review (PASARR) letter dated 9/8/17 revealed Resident #37 was a level II PASARR with no end date.</p> <p>A review of Resident #37's comprehensive minimum data set assessment dated 2/13/19 revealed in question A1500 he was coded to not have a level II PASARR.</p> <p>During an interview on 9/25/19 at 9:07 AM MDS Nurse #1 stated the minimum data set assessment for Resident #37 dated 2/13/19 was incorrect and should have reflected his PASARR Level II status. She stated she would correct the assessment immediately.</p> <p>During an interview on 9/25/19 at 9:20 AM the Administrator stated the facility had identified minimum data set assessments were having issues. She further stated the compliance date for the modifications was 10/31/19 and all areas</p>	F 641			

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F 641	Continued From page 3 were to be reviewed for accuracy. After reviewing Resident #37's assessment dated 2/13/19 she concluded it was incorrect and had not been modified yet. 4. Resident #34 was admitted to the facility on 5/7/12. Her active diagnoses included bipolar disorder. Resident #34's Preadmission Screening and Resident Review (PASARR) letter dated 3/16/15 revealed Resident #37 was a level II PASARR with no end date. A review of Resident #34's comprehensive minimum data set assessment dated 1/22/19 revealed she was coded in question A1500 as not having a level II PASARR. During an interview on 9/25/19 at 9:07 AM MDS Nurse #1 stated the minimum data set assessment for Resident #34 dated 1/22/19 was incorrect and should have reflected his PASARR Level II status. She stated she would correct the assessment immediately. During an interview on 9/25/19 at 9:20 AM the Administrator stated the facility had identified minimum data set assessments were having issues. She further stated their compliance date for modifications was 10/31/19 and all areas were to be reviewed for accuracy. After reviewing Resident #34's assessment dated 1/22/19 she concluded it was incorrect and had not been modified yet.	F 641			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		10/24/19	

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F 657	<p>Continued From page 4</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility failed to update a care plan to reflect the discontinued use of side rails for 1 of 1 resident (Resident #10) reviewed for positioning mobility.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility 12/7/18. Her diagnoses included dementia, atrial fibrillation</p>	F 657	<p>F-657 <input type="checkbox"/> Care plan timing and revision §483.21(b)(2) <input type="checkbox"/> A comprehensive care plan must be <input type="checkbox"/> (iii) reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>Corrective Action for the affected Resident On 09/30/19, resident # 10, care plan was updated to reflect that the side rails were</p>		

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F 657	<p>Continued From page 5 and stage IV pressure ulcer.</p> <p>A review of the significant change minimum data set dated 9/2/19 revealed Resident #10 was severely cognitively impaired. She required extensive assistance for bed mobility and dressing. She was totally depended for her other activities of daily living.</p> <p>A review of the care plan revised on 9/23/19 revealed Resident #10 had a stage IV pressure ulcer to the sacrum related to a history of pressure ulcers and decreased mobility. The interventions included: "The resident needs extensive assistance with use of bed rails for turning and positioning."</p> <p>During an observation on 9/24/19 at 12:38 PM Resident #10 was sitting up in bed feeding herself. The resident's bed did not have side rails attached. A personal care giver who was present during the observation stated when the resident first arrived at the facility the bed had side rails but the rails were removed.</p> <p>On 9/26/19 Wound care nurse #1 stated when Resident #10 had a side rail she could use it. The nurse added Resident #10 was compliant with assistance during dressing changes.</p> <p>On 9/26/19 at 3:30 PM the Administrator stated the care plan was updated for her activities of daily living on 9/18/19 and one of the interventions was for total assistance for bed mobility. She stated the bed rails were no longer an intervention. The Administrator reviewed the care plan again and stated the intervention for her pressure ulcers care plan was not updated correctly to reflect the side rail being removed</p>	F 657	<p>removed from the care plan. Corrective Action for the Resident Potentially Affected The Regional MDS Coordinator reviewed care plans to ensure they were accurate. Any care plans that needed to be revised were corrected. Systemic Changes On 10/03/19, the Regional MDS Coordinator in-serviced the Interdisciplinary Department Team on documenting comprehensive care plans and ensuring accuracy in reports. Quality Assurance The Director of Nursing, the Asst. Director of Nursing and or Nurse Supervisor will randomly monitor 3 care plans weekly for 12 weeks, then monthly using the QI Monitoring Tool to ensure they are accurate. Opportunities to be corrected by the MDS Coordinator and IDT as identified during the Quality monitoring. The results of these reviews to be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month; quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and amend as needed.</p>		

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F 657	Continued From page 6 from the bed.	F 657			
F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to maintain dependent residents' fingernails free of debris and trimmed for 2 of 3 residents reviewed for activities of daily living care. (Resident #37 and Resident #6)</p> <p>Findings included:</p> <p>1. The facility's shower schedule dated 6/13/18 revealed Resident #37 was to receive his shower on Wednesdays and Saturdays.</p> <p>Resident #37's minimum data set assessment dated 7/14/19 revealed he was assessed as cognitively intact and required extensive assistance with personal hygiene.</p> <p>Resident #37's care plan dated 8/24/19 revealed he was care planned to be dependent on staff for activities of daily living care. The interventions included to check nail length and trim and clean on bath day and as necessary.</p> <p>The activities of daily living report for the days of 9/19/19 through 9/25/19 revealed Resident #37 did not refuse personal hygiene care during that time.</p>	F 677	<p>F - 677</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Corrective Action or the Resident Affected For resident #6, and #37, the Certified Nursing Assistant assigned to provide care cleaned his fingernails. Corrective Action for the Resident Potentially Affected On 09/25/19, the Divisional Director of Clinical Nursing and licensed nurses assessed residents by observing their nails. Resident's nails that needed cleaning and trimming were addressed. Systemic Changes On 10/04/19 – The Executive Director, RN initiated an in-serviced to staff on training to the inter-disciplinary team on activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene— emphasizing nail care. Staff is to ask residents during personal care if they would like for their nails to be cleaned, if resident refuses staff will report</p>	10/24/19	

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F 677	<p>Continued From page 7</p> <p>During an interview on 9/23/19 at 3:39 PM Resident #37 stated staff did not help him fully with activities of daily living care. He further stated his fingernails were dirty and not trimmed because staff did not take the time during morning care to clean and trim his fingernails.</p> <p>During observation on 9/23/19 at 3:42 PM Resident #37's fingernails were noted to have white and brown debris packed under the nails and were untrimmed.</p> <p>During observation on 9/24/19 at 9:19 AM Resident #37's fingernails were noted to have white and brown debris packed under the nails and were untrimmed.</p> <p>During observation on 9/24/19 at 3:01 PM Resident #37's fingernails were noted to have white and brown debris packed under the nails and were untrimmed.</p> <p>During an interview on 9/24/19 at 3:02 PM Resident #37 said he did not think to ask to have his nails cleaned and trimmed because he did not feel well that morning during his bath at 9:00 AM. He then stated he did not feel he should have to ask for his nails to be cleaned and trimmed during a bath if they were dirty, but since staff did not take their time, they never noticed dirty fingernails. The resident concluded he had not refused any nail care that week.</p> <p>During an interview on 9/25/19 at 8:18 AM Nurse Aide #1 stated because Resident #37 would go to dialysis in the mornings around 8:00 AM to 8:15 AM on Wednesday he would usually have his shower or bath done by the night shift nurse aide</p>	F 677	<p>to the Nurse Supervisor and document refusal.</p> <p>Quality Assurance The DON, ADON and or Unit Nurses will randomly monitor 3 dependent residents, 3 times a week times 12 weeks, and then monthly to ensure their nail care had been offered/performed utilizing the QI monitoring tool. Opportunities to be corrected by the DON, ADON and or Nurse Supervisor as identified during the Quality monitoring.</p> <p>The results of these reviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and amend as needed.</p>		

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F 677	<p>Continued From page 8</p> <p>prior to her shift. Resident #37 was already up and had his morning care performed when she arrived on the hall today and due to this, she did not give him his shower, but night shift gave him his shower and nail care would be provided during shower days and as needed.</p> <p>During observation on 9/25/19 at 3:08 PM Resident #37's fingernails were still noted to have white and brown debris packed under the nails and were untrimmed.</p> <p>During an interview on 9/25/19 at 3:09 PM Resident #37 stated he had his shower that day, but his nails had not been cleaned or trimmed. He stated he did not ask for them to be cleaned or trimmed because he was tired that morning. He stated he did not refuse nail care that morning.</p> <p>During an interview after observing Resident #37's fingernails on 9/25/19 at 3:14 PM the Director of Nursing stated his fingernails had a lot of debris and needed to be cut. She further stated his nail care should be provided on his bath day and as needed, so if he had not been refusing care, his nails should not have been as unclean and untrimmed as they were. The Director of Nursing concluded that alert and oriented residents should not have to request nail care for it to be performed including Resident #37.</p> <p>2) Resident #6 was admitted to the facility on 12/21/15 with diagnoses which included muscle weakness, congestive heart failure and atrial fibrillation.</p> <p>A review of the significant change minimum data set dated 6/11/19 revealed Resident #6 was severely cognitively impaired and totally dependent of staff for personal hygiene and</p>	F 677			

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F 677	<p>Continued From page 9</p> <p>bathing. She had no behavioral symptoms or rejection of care.</p> <p>A review if the care plan updated on 8/24/19 indicated Resident #6's needs were to be anticipated and met by staff due to impaired cognition. The care plan stated Resident #6 was unable to consistently make her needs known to staff and depended on staff to anticipate and meet all of her needs.</p> <p>During an observation on 9/24/19 at 9:15 AM Resident #6's fingernails on both hands were observed to have brown debris under the nails. The thumb nail on the right hand was observed to be jagged with half of the outer part of the nail broken off with a sharp edge on the piece that remained.</p> <p>On 9/25/19 at 4:17 PM an observation of the fingernails for Resident #6 revealed they remained dirty and the right thumb nail remained jagged with 1/2 of the nail missing. The resident was observed rubbing her index finger along the jagged part of the thumb nail.</p> <p>On 9/25/19 at 4:22 PM Nurse #4 was interviewed and stated she had assisted Resident #6 with her medications today during her scheduled 7:00 AM to 3:00 PM shift and had given the resident a cup of liquid to take the medications. Nurse #4 said she did not notice anything about Resident #6's hands or nails.</p> <p>Nursing Assistant (NA) #4 on 9/25/19 at 4:25 PM. NA #4 reviewed the shower schedule and said nail care should be completed as part of the daily bath and not just completed on shower days. NA #4 observed the fingernails of Resident #6 and</p>	F 677			

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F 677	Continued From page 10 reported her fingernails were long and dirty. She also noted the thumb nail on the right hand was broken off with a jagged edge. During an interview on 9/25/19 at 4:31 PM Nurse #5 stated the NA was responsible for cleaning the resident's nails. Nurse #5 said Resident #6 did not have a diagnosis of diabetes so the NA should clip the nails. Nurse #5 said based on the observation of Resident #6's nails, she would clip the fingernails because they were chipped. On 9/25/19 at 4:41 PM the Director of Nursing (DON) observed the fingernails of Resident #6. The DON said the resident's fingernails needed to be cleaned and trimmed and she would have someone to do that right away.	F 677			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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	F 761		10/24/19	

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F 761	<p>Continued From page 11</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to keep medications secured in a locked treatment cart for 1 of 2 treatment carts observed and failed to discard expired glucometer test strips for 1 of 1 medication preparation rooms observed. (Station 2 Treatment Cart and Station 2 Medication Preparation Room)</p> <p>Findings included:</p> <p>1. During observation on 9/23/19 at 9:45 AM the Station 2 Treatment Cart was observed unlocked and unattended. The lock was observed to be in the unlocked position by the surveyor. At 9/23/19 at 9:46 AM a housekeeper was observed to pass the unlocked cart. At 9:47 AM a nurse aide walked by the unlocked treatment cart. At 9:47 AM another nurse aide walked by the unlocked cart, and at 9:48 AM a resident self-propelled past the unlocked treatment cart. The resident again self-propelled past the treatment cart at 9:49 AM. At 9:51 AM a nurse aide walked past the treatment cart. At 9:51 AM an activates staff member walked past the unlocked treatment cart. At 9:53 AM a maintenance staff member walked past the treatment cart. Nurse #1 returned to view of the cart at 9:54 AM. At 9:55 AM Nurse #1 entered the medication preparation room out of view of the treatment cart. At 9:55 AM a nurse</p>	F 761	<p>F-761</p> <p>√ 483.45(h) <input type="checkbox"/> Storage of Drugs and Biologicals</p> <p>√ 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 keys. Corrective Action for the affected Resident Treatment cart on station 2 was locked by the Director of Nursing. The expired blood glucose strips were removed for the central supply storage room. Medication Carts, Medication Rooms and Medication Room Refrigerators were reviewed for expired medications and issues have no expired medications are maintained without expired medications. Corrective Action for the Resident Potentially Affected The Director of Nursing checked Medication and Treatment Carts to ensure they were locked. Medication carts and Treatment Carts were locked. Medications carts, Medication Rooms and Medication Room Refrigerators and central supply storage rooms were checked to ensure that expired blood</p>	

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F 761	<p>Continued From page 12</p> <p>aide passed the treatment cart. At 9:57 AM the Director of Nursing came into view of the unlocked treatment cart.</p> <p>During an interview on 9/23/19 at 9:57 AM the Director of Nursing stated treatment carts should be locked when unattended. After observing the treatment cart, she confirmed the treatment cart was unlocked. She further stated Wound Care Nurse #1 was responsible for the treatment cart and the last time she saw Wound Care Nurse #1 she was at station 1.</p> <p>During observation on 9/23/19 at 9:58 AM the medications stored in the treatment cart were observed to include a tube of antifungal cream, nonsteroidal anti- inflammatory topical gel, skin moisturizer, another antifungal cream, and antimicrobial wound gel.</p> <p>During an interview on 9/23/19 at 10:01 AM Wound Care Nurse #1 stated she did not leave the cart unlocked and someone else must have unlocked it to remove something. She stated treatment carts were to remain locked when unattended.</p> <p>During an interview on 9/23/19 at 10:03 AM Nurse #1 stated she did not get anything out of the medication cart this morning. She further stated she was the station 2 nurse and that treatment and medication carts were to be locked when unattended.</p> <p>2. An observation was made of the medication preparation room on 9/25/19 at 10:25 AM along with Nurse #1. In the cabinet were 12 boxes (50 strips per box) of blood glucose test strips which were ready for resident use and had an expiration date of 7/11/19.</p>	F 761	<p>glucose strips were not expired. Licensed Nurses were re-educated by the Director of Nursing and or Nurse Supervisor on:09/23/19 with a completion date of 10/18/19</p> <p>MEDICATION ACCESS AND STORAGE A facility is required to secure all medications in a locked storage area and to limit access to authorized personnel (for example, pharmacy technicians or assistants who have been delegated access to medications by the facility <input type="checkbox"/> pharmacist as a function of their jobs) consistent with state or federal requirements and professional standards of practice. Storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts. Depending on how the facility locks and stores medications, access to a medication room may not necessarily provide access to the medications (for example, medications stored in a locked cart, locked cabinets, a locked refrigerator, or locked drawers within the medication room). When medications are not stored in separately locked compartments within a storage area, only appropriately authorized staff may have access to the storage area. The Facility will incorporate this training in the orientation process for new hires. Licensed Nurses were re-educated by the Director of Nursing and or Nurse Supervisor on: Labeling of Drugs and Biologicals For over-the-counter (OTC) medications in bulk containers (e.g., in states that</p>		

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F 761	<p>Continued From page 13</p> <p>An interview with Nurse #1 on 9/25/19 at 10:25 AM verified the blood glucose test strips were ready for resident use and were expired. She further stated they should have been removed from the medication preparation room.</p> <p>An interview with the Central Supply Clerk on 9/25/19 at 12:07 PM indicated she checked the medication preparation room monthly for expired items. She stated she was reading the blood glucose test strip expired date incorrectly as 11/7/19 and thought they were still within date. She stated she had talked with the Director of Nursing who had contacted the manufacturer and now understood she had read the date incorrectly and the blood glucose test strips were expired and should have been discarded.</p> <p>An interview with the Director of Nursing (DON) on 9/25/19 at 10:43 AM verified the blood glucose test strips were expired and stated they should have been removed from the medication preparation room. She further stated the Central Supply Clerk was responsible for checking the medication rooms and should discard expired items. The DON also stated they contacted the manufacturer to verify the date was read correctly and verified the blood glucose test strips had an expiration date of 7/11/19.</p> <p>An interview with the Administrator on 9/25/19 at 3:10 PM indicated there should not be any expired medications or blood glucose test strips stored in any areas of the facility.</p>	F 761	<p>permit bulk OTC medications to be stocked in the facility), the label contains the original manufacturer's or pharmacy-applied label indicating the medication name, strength, quantity, accessory instructions, lot number, and expiration date when applicable. The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements.</p> <p>The Facility will incorporate this training in the orientation process for new hires.</p> <p>Systemic Changes The Director of Nursing and or Nurse Supervisor will monitor medication carts, treatment carts and room randomly 3 times a week for 12 weeks, then monthly using the QI Monitoring Tool to ensure they are locked and secure.</p> <p>Opportunities to be corrected by the DCS and or Nurse Supervisor as identified during the Quality monitoring.</p> <p>Quality Assurance The Director of Nursing and or Nurse Supervisor will monitor blood glucose strips, and other medication or supplies that have an expiration date to ensure that it is accurate and consistent with applicable state requirements 3 times a week for 12 weeks, then monthly using the QI Monitoring Tool to ensure if item has expired it has been removed.</p> <p>The results of these reviews to be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month; quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the</p>		

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F 761	Continued From page 14	F 761	effectiveness and amend as needed.		
F 812 SS=E	<p>Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to label food items stored in 1 of 1 walk in refrigerator and 1 of 1 nourishment refrigerator.</p> <p>The findings included: During an observation of the walk-in refrigerator located in the kitchen on 9/23/19 at 9:45 AM an opened container of potato salad was observed. The container was clear plastic container with a red lid. There was no label on the container or lid to identify the contents or the date it was placed</p>	F 812	<p>F <input type="checkbox"/> 812 <input type="checkbox"/> §483.60(i) Food safety requirements. The facility must <input type="checkbox"/> §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. Corrective Action for the Resident Affected Food container found in walk-in refrigerator and nourishment refrigerator without a label and date were removed by the Dietary Manager. Corrective Action for Residents Potentially</p>	10/24/19	

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F 812	<p>Continued From page 15 into the refrigerator.</p> <p>During the observation on 9/23/19 at 9:48 AM the Dietary Manager stated he was unsure when the potato salad was made or when it was on the menu.</p> <p>During an interview with the Dietary Manager on 9/25/19 at 3:50 PM he stated the opened container of potato salad should have a label with the name of the product and the date it was placed into the refrigerator. He stated leftover food items made at the facility were kept for 3 days but he did not know when the potato salad was made since there was not label on it.</p> <p>A review of the "Storage Guidelines for Food From Outside the Facility for Staff" with a release date of 08/2017 stated "Stored items must be in an airtight package or a sealed container with the resident's name, contents and the date they were placed in storage."</p> <p>An observation of the nourishment refrigerators on 9/25/19 at 3:50 PM revealed the nourishment refrigerator located inside the Unit 2 nourishment room contained a white plastic bag. The bag contained a black foam plate on top of another foam plate which contained food. There was no label or information to identify the date the bag was place into the nourishment refrigerator, the resident's name or the resident's room number on the bag.</p> <p>During an interview with the administrator on 9/26/19 at 12:30 PM she thought the food in the nourishment refrigerator belonged to a staff member because the facility had previously checked the refrigerator to ensure the items</p>	F 812	<p>Affected Reach in refrigerator and other nourishments refrigerators were checked to ensure there were not items stored without dates and labels. No other items found.</p> <p>Systemic Changes On 9/25/19, an in-service was initiated by the Dietary Manager on Food Safety Requirements and Refrigerated Storage for facility staff: The completion date of in-servicing will be 10/18/19</p> <p>Foods must be maintained at or below 41 degrees F, unless otherwise specified by law. Frozen foods must be maintained at a temperature to keep the food frozen solid. Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms. Inadequate temperature control during refrigeration can promote bacterial growth. Adequate circulation of air around refrigerated products is essential to maintain appropriate food temperatures. Foods in a walk-in unit should be stored off the floor. Practices to maintain safe refrigerated storage include: <ul style="list-style-type: none"> ¿Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation; ¿Placing hot food in containers (e.g., shallow pans) that permit the food to cool rapidly; ¿Separating raw foods (e.g., beef, fish, lamb, pork, and poultry) from each other and storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods; and </p>		

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F 812	Continued From page 16 inside the refrigerator were dated. The Administrator said the staff member should not have placed the staff member's food into the resident nourishment refrigerator because there was a separate staff refrigerator in the employee break room for staff to place their food. During an interview with the Dietary Manager on 9/25/19 at 3:50 PM he stated all items in the refrigerators should have a label which indicated the date the item was placed in the refrigerator.	F 812	¿ Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded. The facility will implement this training for new hires during the orientation process. Quality Assurance The Dietary Manager and or Dietary Cook will monitor the refrigerators in the kitchen and the nourishments refrigerators 2 times a day for 12 weeks then weekly to ensure that foods are labeled and dated utilizing the QI Monitoring Tool. Opportunities to be corrected by the Dietary Manager and or Dietary Cook as identified during the Quality monitoring. The results of these reviews to be submitted to the QAPI Committee by the Dietary Manager for review by the IDT members monthly; quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and modify monitoring as needed.		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities.	F 919		10/24/19	

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F 919	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility utilized a call system which allowed for resident call bells to be deactivated without entering the resident's room for 21 of 44 semiprivate rooms (Rooms: 116, 117, 121, 122, 144, 147, 148, 195, 196, 199, 200, 217, 218, 225, 226, 229, 230, 250, 251, 254, 255)</p> <p>Findings included:</p> <p>An interview on 9/25/19 at 2:35PM during the Resident Council meeting with Resident #43 revealed there was an issue with her bedside call bell which she wanted investigated. Resident #43 stated if her call bell was on and the call bell in the shared bathroom was on and then the call bell in the shared bathroom was turned off, her call bell was turned off without staff entering her room to deactivate it.</p> <p>Resident #43 was admitted to the facility on 5/11/12 with reentry on 1/21/17 with diagnoses which included rheumatoid arthritis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 8/1/19 indicated Resident #43 was cognitively intact.</p> <p>Observations of the bedside call bell for Resident #43 in Room 195 on 9/25/19 at 3:00 PM indicated the call bell was deactivated when the shared bathroom call bell was turned off. The call bell for bed A was activated and the light in the hallway by the room door was turned on. The shared bathroom call bell was activated and the light in the hallway by the room door was turned on. Then the shared bathroom call bell was</p>	F 919	<p>F-919 §483.90(g)(1) - The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. Corrective Action or the Resident Affected For Resident #43, a hand call bell was offered and she refused stating that "I have one; I don't use it. I can holler loud enough for someone to hear me." Corrective Action for the Resident Potentially Affected On 9/25/19, the Maintenance Director and Director of Social Services audited call lights, including bathroom call lights to identify which bedside call lights are inactivated when a bathroom call light is deactivated. On 9/25/19, ED notified the Regional Vice-President of Operations and the District Director of Safety about the call-light system. District Director of Safety contacted vendor to arrange for an assessment of the call-light system to ensure it was working as designed. On 10/08/19, Bradley Electrical Service assessed the call light system. Electrician contacted the vendor (Med-Teck) that manufactured the call light apparatus installed in the wall and in the bathroom. According to the manufacture, the system was designed the way that it was performing and installed in 1992. The electrician was able to re-wire the</p>		

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F 919	<p>Continued From page 18</p> <p>deactivated and the call bell for bed A was also deactivated at the same time.</p> <p>Observations of the bedside call bell in rooms 196, 197, 198 and 199 on 9/25/19 at 4:00 PM revealed the same situation where the call bell was deactivated in one of the adjoining rooms when the shared bathroom call bell was turned off. This was the same for bed A and bed B in 1 of the 2 resident rooms with the shared bathroom between the rooms.</p> <p>Observations during a facility wide call bell testing and tour of the facility on 9/26/19 at 11:15 AM with the Maintenance Director (MD) indicated 21 of 44 semiprivate rooms at the facility had call bells with shared bathrooms in which the call bell was deactivated in the resident's room when the shared bathroom call bell was turned off.</p> <p>An interview with the MD on 9/25/19 at 5:14 PM indicated he was unaware the call bell was deactivated from the bathroom call bell without staff entering the resident's room. He stated an electrician would have to investigate the call bell system. He further stated he randomly checked call bells weekly and was unaware of any functional issues.</p> <p>An interview on 9/25/19 at 5:17 PM with Nurses Aide (NA) #2 indicated she had been employed at the facility for 4 years and was unaware of the call bell system problem.</p> <p>An interview on 9/25/19 at 5:20 PM with NA #3 revealed she had been employed at the facility for 7 years and was not aware of the call bell system problem.</p>	F 919	<p>room and install a 3 way light outside of the residents rooms so each signal is wired to its own light box. He also confirmed that the call light system at the central nurses station worked properly with the re-wiring configuration.</p> <p>On 9/26/19, the facility identified residents that are alert-and-oriented with BIMS of 8 or greater affected by the call-light that is inactivated with a bathroom when a bathroom call light is deactivated. Residents were provided hand bells and educated on how to use the hand-bell in the event that their call-light is not answered or is turned off due to a bathroom call light deactivation. Nursing staff have also been educated on following up all bathroom signals with a check on the room that is affected by the overriding bathroom light, in an effort to ensure that call bells are answered.</p> <p>Systemic Changes</p> <p>On 9/25/19 an in-service was initiated by the Director of Nursing and Unit Managers to staff on the call light system. The in-service consisted of residents rooms that are affected by bedside signal deactivation. Staff was instructed of the residents that have hand call bells and to respond if hand call bells are rung.</p> <p>Quality Assurance</p> <p>DON, Unit Manager, and Maintenance Director will randomly monitor the hand bell call system twice a day, three times a week, until the re-wiring is completed to ensure the hand bells are responded to in a timely manner. Following the electrical configuration the Maintenance Director will monitor the call light system 3 times a</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 919	<p>Continued From page 19</p> <p>An interview on 9/25/19 at 5:24 PM with Nurse #2 revealed she had been employed at the facility for 2 years and was unaware of the call bell system problem.</p> <p>An interview on 9/25/19 at 5:27 PM with Nurse #3 indicated she had been employed at the facility for 4 years and was unaware of the call bell system problem.</p> <p>An interview on 9/26/19 at 9:45 AM with the Director of Nursing (DON) revealed she was unaware the call bell system was deactivated from the shared bathroom without staff entering the resident's room.</p> <p>An interview on 9/26/19 at 1:59 PM with the Administrator revealed she was unaware the call bell system was deactivated from the shared bathroom without staff entering the resident's room and stated it was the way the call bell system was designed when the building was built.</p>	F 919	<p>week for 12 weeks; then monthly using the QI Monitoring Tool to ensure that the system works appropriately. The results of these reviews will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate the effectiveness and amend as needed.</p>		