STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036		10/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2019

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E 036	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an annual emergency preparedness training program for facility staff. The findings included: During a review of the facility's emergency preparedness manual on 9/26/19, the manual did not include information on annual training of the emergency preparedness plan for facility staff. An interview on 9/26/19 at 4:00 PM with the Administrator revealed she the Maintenance Director was responsible for the annual training of staff for the emergency preparedness plan and she did not know why it didn't all get done. An interview on 9/26/19 at 4:16 PM with the Maintenance Director revealed he was aware that staff had to be trained annually on emergency preparedness, but he just didn't get it all documented.	E 036	The Maintenance Director provided the annual emergency preparedness training to staff in all departments by 10-23-19. On 10-4-19, the Executive Director reviewed the annual emergency preparedness training provided earlier this year and found it was not comprehensive nor provided to all staff. On 10-14-19, the Executive Director and the Maintenance Director prepared comprehensive annual emergency preparedness training. The Executive Director provided education to the Maintenance Director on 10-4-19 regarding having a comprehensive annual emergency preparedness training that will include staff from all departments. On 10-23-10, the Executive Director reviewed the attendance sheets from the annual emergency preparedness training to ensure compliance. The Executive Director added to the outlook Calendar for the Executive Director and the Maintenance Director on 10-17-19 for a planning meeting on October 1st 2020. Added to the Maintenance Director's monthly Quality Assurance tool was the date for the planning meeting for October 1st 2020 and the dates of the education that will take place on October 13-17, 2020 so that all Quality Assurance Performance Improvement members will review this information monthly for heightened awareness and future	

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E 036	Continued From page 2	E 036	compliance. The Maintenance Director will verbally report this information each month at the Quality Assurance Performance Improvement committee meeting going forward.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		10/23/19

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F 578	Continued From page 3 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to accurately transcribe the Advance Directive of 1 of 1 sampled resident (Resident #56) reviewed. Findings included: Resident #56 was admitted to the facility on 2/21/19 with diagnoses which included: Alzheimer's disease, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, chronic atrial fibrillation, and chronic pain. Review of the quarterly minimum data set dated 8/30/19 indicated Resident #56 was severely, cognitively impaired. The review of the Physician's Order dated 2/21/19 read: "Resident is to be DNR" (do not resuscitate). Review of the portable medical form with the effective date of 2/21/19 which was placed in the resident's medical record, documented Resident #56's Advance Directive status as DNR (Do Not Resuscitate).	F 578	1. Resident #56's physician was notified and a telephone order for this resident to be a DNR was obtained. 2. On 10-16-19, the Social Worker and the Medical Records Coordinator completed a review of current residents to ensure the portable medical form, the original code status order and the current physician's orders matched regarding code status. Discrepancies were brought to the attention of the RN Unit Manager to be addressed with the physician at that time. 3. The Director of Nursing provided education to the licensed nurses by 10-22-19 regarding the importance of checking the portable medical form, the original code status order against the physician's order sheets at the end of each month to ensure the code status is carried forward to the next month correctly. The Director of Nursing also provided this education to the Social Worker, the Social Work Assistant the Medical Records Coordinator on 10-15-19.	

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F 578	Continued From page 4 The review of the monthly Physician's Orders for the months of February 2019 through September 2019 documented Resident #56's Advance Directive status as Full Code (emergent measures in attempt to resuscitate the patient). During an interview on 9/26/19 at 4:35 p.m., the Administrator confirmed the discrepancy between the original physician's order, the portable advance directive and the monthly Physician's Orders should not have occurred. She indicated facility staff should have noticed Resident #56's incorrect advance directive status beginning with the February 2019's Physician's Orders and made the correction when the monthly orders were reconciled.	F 578	4. The Social Services Director or the Social Services Assistant, along with the Medical Records Coordinator will complete quality improvement monitoring of the portable medical forms, the original code status orders and the next month's physician's orders the last work day of every month to ensure compliance. Discrepancies will be brought to the Director of Nursing to be addressed upon identificatoin. The results of this audit will be brought to the monthly QAPI committee meeting.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		10/23/19

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F 582	Continued From page 5 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from	F 582	1. On 10-14-19, the Business Office Manager, the Social Worker, the Social Worker Assistant and the Executive Director had education provided via a webinar by the Regional Director of	

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F 582	Continued From page 6 Medicare part A services to two of three residents (Resident #72 and Resident #26) reviewed for SNF Beneficiary Protection Notification Review. Findings included: 1. Resident #72 was admitted to the facility on 2/14/18. Medicare part A services began on 5/6/19. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #72 on 7/19/19. The notice indicated that Medicare coverage for skilled services was to end 7/22/19. The resident remained in the facility when Medicare coverage ended. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative. An interview was completed with the Social Worker (SW) on 9/25/19 at 11:38 AM. She stated either the business office manager or therapy department notified her when a resident came off Medicare part A services. Once she was notified, the SW completed the NOMNC notice with either the resident or resident representative within 24 hours. The SW reported she had no knowledge of the ABN form and had not completed one with Resident #72 when Medicare part A services ended. Attempts to interview the former business office manager were unsuccessful. An interview was completed with the Administrator and Regional Nurse Consultant on	F 582	Business Office regarding providing Advanced Beneficiary Notices to residents when their is a change in payer status that may affect their charges. 2. On 10-2-19, the Executive Director reviewed the files of all current residents and determined that current residents had not been provided with Advanced Beneficiary Notices. 3. On 10-14-19, the Business Office Manager, the Social Worker, the Social Worker Assistant and the Executive Director had education provided via a webinar by the Regional Director of Business Office regarding providing Advanced Beneficiary Notices to residents when their is a change in payer status that may affect their charges. This education will be provided to newly hired Business Office staff members during their orientation. The Executive Director will complete quality monitoring of 5 residents per month with payer changes that remain in the facility for 6 months. The Executive Director will report on the results of the quality monitoring to the QAPI committee. Finding will be reviewed by the QAPI committee monthly and quality monitoring updated as indicated,	

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F 582	Continued From page 7	F 582		

9/25/19 at 4:02 PM, during which the Administrator said she thought the SW had not been educated regarding the completion of the ABN form. The Administrator reported she thought the business office was responsible for ABN forms and the SW was responsible for completion of NOMNC forms. She stated the facility had two different business office managers in the past year and, at present, the position was open. The Regional Nurse Consultant added the business office managers were trained in the completion of ABN forms. The Administrator's expectation was that ABN forms were completed when a resident was discharged from Medicare part A services.

2. Resident #26 was admitted to the facility on 4/20/18. Medicare part A services began on 7/25/19.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #26 on 8/7/19. The notice indicated that Medicare coverage for skilled services was to end 8/9/19. The resident remained in the facility when Medicare coverage ended.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or resident representative.

An interview was completed with the Social Worker (SW) on 9/25/19 at 11:38 AM. She stated either the business office manager or therapy department notified her when a resident came off Medicare part A services. Once she was notified, the SW completed the NOMNC notice with either the resident or resident

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F 582	Continued From page 8 representative within 24 hours. The SW reported she had no knowledge of the ABN form and had not completed one with Resident #26 when Medicare part A services ended. Attempts to interview the former business office manager were unsuccessful. An interview was completed with the Administrator and Regional Nurse Consultant on 9/25/19 at 4:02 PM, during which the Administrator said she thought the SW had not been educated regarding the completion of the ABN form. The Administrator reported she thought the business office was responsible for ABN forms and the SW was responsible for completion of NOMNC forms. She stated the facility had two different business office managers in the past year and, at present, the position was open. The Regional Nurse Consultant added the business office managers were trained in the completion of ABN forms. The Administrator's expectation was that the ABN forms were completed when a resident was discharged from Medicare part A services.	F 582		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		10/23/19

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F 644	Continued From page 9 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to refer a resident with a newly evident diagnosis of serious mental illness for a level II PASARR (Preadmission Screening and Resident Review; the purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid certified nursing facilities receive appropriate placement and services) for 1 of 1 resident (Resident #44) reviewed for PASARR. Findings included: Resident #44 was admitted to the facility on 1/11/16. He did not have a mental illness diagnosis at the time of admission. He had a level I PASARR number. A review of the admission Minimum Data Set (MDS) assessment dated 1/16/16 revealed no psychiatric diagnoses. A review of a significant change MDS assessment dated 7/26/19 revealed an active diagnosis of schizophrenia. Further review of the MDS assessment revealed Resident #44 received antipsychotic and antianxiety medications for 7 of 7 days during the MDS look	F 644	1. Resident #72's PASRR was sent for review by the Social Services Assistant on 9-30-19. 2. On 10-17-19, the Director of Nursing, Unit Manager and Minimum Data Set Nurse reviewed all current residents diagnosis and psychological progress notes to validate residents had the correct level PASRR in the medical record. Issues were addressed. 3. The Executive Director educated the MDS Coordinator that when she identifies new psychiatric diagnoses,to notify the Social Services Director and the Social Services Assistant so that the PASRR can be sent for review on 9-26-19. The Director of Nursing educated the psychological services on notifying the facility of added or changed diagnoses to a resident so that the facility can determine if a PASRR review is needed on 10-22-19. The Social Services Director or the Social Services Assistant will be responsible for making the referral if needed.	

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F 644	Continued From page 10 back period. On 9/24/19 at 9:26 AM a review of Resident #44's current PASARR number provided by the facility social worker (SW) revealed a level one PASARR number. A review of the facesheet for Resident #44 revealed a diagnosis of schizoaffective disorder with an onset date of 2/5/18. The classification on the facesheet indicated the diagnosis was obtained "during stay." On 9/25/19 at 12:36 PM an interview was completed with the Administrator. She reported the MDS Coordinator entered all diagnoses into the computer which was then transferred on to the resident's facesheet. On 9/25/19 at 9:23 AM an interview was completed with the SW, during which she revealed the Nurse Liaison verified PASARR numbers prior to admission to the facility. The SW said if a resident developed mental illness while at the facility either the Nurse Liaison or SW Assistant completed a referral for a level II PASARR screening. The SW further stated a Medicaid meeting was held weekly which included discussions about residents. If there was any newly identified mental illness discussed, then a level II PASARR was initiated. During an interview with the Nurse Liaison on 9/26/19 at 9:13 AM, she confirmed either herself or the SW Assistant verified PASARR numbers upon admission. She stated if a resident developed mental illness while at the facility then a level II PASARR was completed by the SW Assistant.	F 644	4. The Director of Nursing will complete quality monitoring of 10 resident's psychological progress notes for new diagnoses and 10 diagnoses sheets 1 time a week for 3 months, then monthly for 3 months to ensure new psychological diagnose is captured and referral to PASRR if needed. The Director of Nursing will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement Committee monthly and quality monitoring updated as indicated.	

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F 644	Continued From page 11 On 9/26/19 at 9:25 AM an interview was completed with the SW Assistant. She reported she had worked in her current position for about a month and said typically she was notified by staff if there was a change of condition on a resident that required a level II PASARR referral. The MDS Coordinator was interviewed on 9/25/19 at 3:20 PM. She stated Resident #44 was not originally admitted with a diagnosis of schizophrenia. She reported the diagnosis was first recorded on a psychiatric consult note on 1/30/17. The MDS Coordinator indicated she typically reviewed consult diagnoses and then entered them on to the diagnosis list which went on the resident's chart. A review of a psychiatric note dated 1/30/17 revealed a diagnosis of "unspecified schizophrenia spectrum and other psychotic disorder." A follow up interview was completed with the Administrator on 9/25/19 at 4:12 PM. She confirmed the diagnosis of schizophrenia for Resident #44 originated while the resident was in the facility. She said the MDS Coordinator was unaware she needed to notify the Administrator of the new diagnosis so a level II PASARR could be initiated. She stated her expectation was that a PASARR application was "sent up for review" when a resident was newly diagnosed with a mental illness.	F 644		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		10/23/19

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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(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 686	Continued From page 12 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow a physician ordered intervention for the use of pressure reduction of the heels for 2 of 3 residents (Resident #10 and Resident #5) reviewed for pressure ulcers. The findings included: 1. Resident #10 was admitted to the facility on 1/17/14. Her diagnoses included, in part, chronic kidney disease, dementia and peripheral vascular disease. A physician's order dated 4/24/19 read "offload heels with pillows while in bed". A quarterly Minimum Data set assessment dated 7/3/19 revealed Resident #10 had severely impaired cognition, required extensive assistance with two people for bed mobility, was dependent for transfers, non-ambulatory and incontinent of bowel and bladder. She was at risk for developing pressure ulcers. Resident #10 had a Stage 3	F 686	1. The Director of Nursing validated the foot bolsters was properly paced on Resident's #'s 5 and 10 to promote wound healing. 2. On 10-2-19, the Director of Nursing and Unit Managers reviewed current residents utilizing foot bolsters to ensure proper application and documentation per plan of care. Issues identified were addressed. 3. The Director of Nursing re-educated nursing staff on properly applying foot bolsters to prevent/promote wound healing completing by 10-22-19. This education will be provided to newly hired nursing staff during their orientation period. 4. The Director of Nursing will complete quality monitoring of 3 residents with foot bolsters to ensure that the foot bolsters were applied per plan of care and documented 3 times a week for 3 months,	

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F 686	Continued From page 13 pressure ulcer. Resident #10 utilized a wheelchair and had a pressure reducing device to her wheelchair and bed. A wound care report dated 9/4/19 by the physician's assistant revealed Resident #10 had a Stage 3 pressure ulcer to her left heel measuring 4 x 2 x 0.1. The report stated, "recommend offloading boots or offloading with pillows. Patients heels need to be offloaded while she is in bed". An observation on 9/23/19 at 10:53 AM of Resident #10 revealed she was lying in bed with her heels resting flat on the mattress. An observation on 9/25/19 at 9:36 AM of Resident #10 revealed she was lying in bed with her heels resting flat on the mattress. An interview with Nursing Assistant (NA)#1 on 9/26/19 at 10:39 AM revealed she knew if residents needed to have their heels floated by the nurse or the information in the Kardex. She didn't know why Resident #10 didn't have her heels floated, she stated she didn't usually work the hall Resident #10 was on. An observation of wound care on 9/26/19 at 10:41 AM revealed Resident #10 had a large area to her left inner heel. There was a scabbed over area to the wound and another smaller patchy area that was observed to be darkened and non-blanchable. The wound was not observed to have any signs or symptoms of infection. The skin around the wound was intact without redness. Wound care was observed by the hall nurse without concerns.	F 686	then monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement committee. Findings will be reviewed by the Quality Assurance Performance Improvement committee monthly and quality monitoring updated as indicated.	

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F 686	Continued From page 14	F 686		

An interview with Nurse #1 on 9/26/19 at 10:41 AM revealed she tries to check for pressure reducing devices when she is making her rounds. She stated she tells her nursing assistants to do it, but sometimes they don't.

An interview with the Director of Nursing on 9/26/19 at 11:34 AM revealed it was the nursing assistants who should be applying pressure reducing devices per the physician's orders and the expectation of the hall nurse to ensure that they are in place.

2. Resident #5 was admitted to the facility on 2/8/16 with diagnoses of, in part, diabetes mellitus, dementia and malnutrition.

A quarterly Minimum Data Set assessment dated 7/2/19 revealed Resident #5 had severely impaired cognition and required extensive assistance with two people for bed mobility. She was non-ambulatory and incontinent of bowel and bladder. Resident #5 was identified as at risk for pressure ulcers and had a current unstageable area during the look back period.

A wound care note by a physician's assistant dated 8/28/19 revealed the area to Resident #5's left heel was resolved. The note stated, "resolved wounds do not achieve their original tensile strength. It is possible for wounds to recur ...could benefit from continuing skin prep and offloading heels".

The resident's September 2019 physician orders indicated Resident #5 was to have her heels offloaded with pillows. The orders also a treatment to clean the left heel with normal saline, pat dry and apply skin prep every shift.

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F 686	Continued From page 15	F 686		

An observation on 9/23/19 at 2:45 PM revealed Resident #5 in her bed with her heels lying flat on a heel bolster.

An observation on 9/25/19 at 9:36 AM revealed Resident #5 in her bed with her heels lying flat on a heel bolster.

An observation on 9/25/19 at 2:16 PM revealed Resident #5 lying in bed with her legs on a heel bolster and her feet lying flat on the mattress.

An observation on 9/26/19 10:53 AM of wound care to Resident #5's left heel by Nurse #1 revealed a small area to the left heel that was unopened with flaky dry skin.

An interview with Nursing Assistant (NA) #1 on 9/26/19 at 10:39 AM revealed she knew if residents needed to have their heels floated by the nurse or the information in the Kardex. She didn't know why Resident #5 didn't have her heels floated, she stated she didn't usually work the hall Resident #5 was on.

An interview with Nurse #1 on 9/26/19 at 10:41 AM revealed she tries to check for pressure reducing devices when she is making her rounds. She stated she tells her nursing assistants to do it, but sometimes they don't.

An interview with the Director of Nursing on 9/26/19 at 11:34 AM revealed it was the nursing assistants who should be applying pressure reducing devices per the physician's orders and the expectation of the hall nurse to ensure that they are in place.

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F 688	Continued From page 16	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to apply the left-hand splint as ordered by the physician for 1 of 1 sampled resident (Resident #28) with a contracture of her left hand. Findings included: Resident #28 was admitted to the facility on 2/5/19 with diagnoses which included: hemiplegia and hemiparesis following a CVA (cerebrovascular accident) affecting the left non-dominant side, and a left-hand contracture. Review of the quarterly minimum data set dated	F 688	1. Resident #28's splint was applied by nurse per orders on 9-26-19 and documented on the medication administration record. 2. On 10-2-19 the Director of Nursing and Unit Managers reviewed the orders of current residents to ensure that residents with splints had them applied and documented per the physician's orders. Issues identified were addressed. 3. The Director of Rehabilitation re-educated the Director of Nursing and the Unit Manager on splint application and removal on 10-1-19. The Director of	10/23/19

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F 688	Continued From page 17 8/5/19 indicated Resident #28 was cognitively intact and had upper and lower range of motion impairment on one side. Review of the Care Plan updated on 8/15/19 revealed the resident had the potential for ADL (activities of daily living) self-care performance deficit related to her diagnosis of a CVA, left sided hemiplegia. Approaches included: the resident was to wear a left-hand brace 5-6 hours each day, check skin beneath brace to ensure skin integrity. The review of the Physician's Order dated 8/15/19 documented Resident #28 was to have a left-hand splint applied for 5-6 hours a day for her left-hand contracture; and the skin beneath the resident's left-hand splint was to be checked every shift and report any skin breakdown. A review of the August 2019's TAR (treatment administration record) documented the left-hand splint was applied to Resident #28's left hand at 6:00 a.m. and removed at 12:00 p.m. However, the review of September's TAR revealed no documentation indicating the left-hand splint was applied as ordered from September 1, 2019 through September 26, 2019. During an observation on 9/24/19 at 11:02 a.m., three nursing assistants were observed in Resident #28's room preparing to transfer the resident from her bed to a wheelchair. The resident's left hand was contracted, but she was not wearing a splinting device. During an observation and interview on 9/24/19 at 11:26 a.m., Resident #28 was sitting upright in her wheelchair in her room. There was no	F 688	Nursing re-educated licensed nurses on splint application, removal and proper documentation by 10-22-19. This education will be provided to newly hired nurses during the orientation process. 4. The Director of Nurses will complete quality monitoring of 5 residents with splints to ensure splint is applied per plan of care, documented on the Treatment Administration Record, 3 times a week for 3 months, then monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement committee. Finding will be reviewed by the Quality Assurance Performance Improvement committee monthly and quality monitoring updated as indicated.	

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F 688	Continued From page 18 splinting device on the resident's contracted left-hand. The resident stated that she only wore the left-hand splint during the night hours. During an interview on 9/26/19 at 11:00 a.m., the Physical Therapist stated that Resident #28 had a diagnosis of CVA and was admitted to the facility with the left-hand splint for a contracture. He revealed the resident was discharged from therapy on 3/25/19 with HEP (home exercise program-self performing) for her contracted left hand. During an interview on 9/26/19 at 12:03 p.m., Nurse #1 stated that Resident #28 had a left-hand splint which was applied by nursing for 5 hours each day. She revealed the splint was usually applied to the resident's left hand at 6:00 a.m. During an interview on 9/26/19 at 12:08 p.m., Nurse Manager #1 stated that it was the responsibility of the facility's nurses to apply the splint to Resident #28's left hand contracture and document on the TAR that it was applied. after reviewing September 2019's TAR, Nurse Manager #1 acknowledged the application of the left-hand splint to the resident's left, contracted hand was not documented, but should have been.	F 688		
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	F 761		10/23/19

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F 761	Continued From page 19 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard 2 syringes of expired medication (heparin solution) and 1 bottle of an expired reagent (hemoccult developer) in 1 of 2 (long hall) medication storage rooms. The findings included: An observation on 9/24/19 at 1:40 PM of the Medication Storage room on the long hall revealed 2 5ml syringes of heparin lock flush solution lot #802963N with an expiration date of 7/31/19 and 1 bottle of hemoccult developer with an expiration date of 8/2019. An interview conducted on 9/24/19 at 1:50 PM with Unit Manager #1 revealed day shift checks	F 761	1. The expired heparin syringes and the expired bottle of hemacult developer was removed from the medication room and disposed of by the Unit Manager on 9-24-19. 2. A review of medication carts and medication rooms was performed by the Director Of Nursing and Unit Managers to ensure medications are within date on 9-30-19. Issues were addressed. 3. The Director of Nursing re-educated licensed nursing staff on expired medications to include syringes of medication and hemacult developer by 10-22-19.	

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F 761	Continued From page 20 the medication storage rooms every day but they don ' t look at everything every day. She stated the Unit Managers are responsible but do overlook things sometimes. An interview conducted on 9/26/19 at 11:04 AM with the Director of Nursing revealed the Unit Managers are responsible for checking the medication storage rooms for expired medications and it usually gets done monthly.	F 761	4. The Director of Nursing or Unit Manager will complete quality monitoring of medication carts and medication rooms 2 times weekly for 12 weeks, then monthly to validate that medications are within date for use. Opportunities will be corrected by the Director of Nursing as identified during the quality monitoring. The Director of Nursing will report on the results of the quality monitoring and report to the Quality Assurance Performance Improvement Committee monthly. Findings will be reviewed by the Quality Assurance Performance Improvement Committee monthly and the quality monitoring will be updated as needed.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		10/23/19

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F 812	Continued From page 21 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to safely store and transport lunches in a sanitary manner for the dialysis residents transported to the dialysis center. Findings included: During the initial tour of the kitchen on 9/23/19 at 11:30 a.m., there were no insulated lunch bags or coolers for use by dialysis residents located in any of the storage areas. There were large clear, plastic sandwich bags in a drawer beneath one of the preparation tables in the kitchen. The dietary cook stated that the kitchen provided packed lunches in ziplocked plastic bags and were transported with the three dialysis residents to the dialysis center. She indicated only one of the three dialysis residents went to the dialysis center that morning, (Resident #21). The dietary cook revealed Resident #21's packed lunch included an egg salad sandwich. The cook and the Dietary Manager were unsure how the plastic bag containing the egg salad sandwich was stored during transportation to the dialysis center. During an interview on 9/23/19 at 11:45 a.m., the facility's van driver revealed there was no insulated food/beverage cooler on the van. She stated that she usually kept the dialysis residents' lunches on a platform area next to the driver's seat on the van. On 9/23/19 at 11:48 a.m., the Dietary Manager acknowledged and stated that the dialysis	F 812	1. Insulated lunch bags with cold packs were provided for dialysis residents on 9-23-19. 2. A review of the charges all residents was completed on 9/23/19 to ensure the inclusion of all dialysis residents by the Director of Nursing and the executive Director. 3. On 9-23-19, the Director of Nursing re-educated licensed nursing staff, the Dietary Manager, the dietary staff and the transportation staff regarding the need to ensure safe temperatures of food being transported to dialysis for the dialysis dependent residents, utilizing insulated bags and cold packs. 4. The Dietary Manager will complete an audit of 2 times weekly for 4 weeks, then weekly for 12 weeks, then monthly to ensure compliance with the utilization of the cold packs and insulated lunch bags when transporting lunches to dialysis for affected residents on dialysis days. Opportunities will be corrected by the Dietary Manager as identified during the quality monitoring. The Dietary Manager will report on the results of the quality monitoring to the Quality Assurance Performance Improvement Committee monthly. The quality monitoring will be updated accordingly.	

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F 812	Continued From page 22	F 812		

residents' lunches should have been stored in insulated containers when transported with the residents to the dialysis center. He indicated he would immediately obtain the necessary containers to ensure the lunches for the three dialysis residents would be safely transported.

During an interview on 9/24/19 at 9:25 a.m., Resident #21 who was cognitive intact and had a diagnosis of end-stage renal disease, stated that she received dialysis treatments on Mondays, Wednesdays and Fridays. The resident stated she was transported to the dialysis center on the facility's van at 9:30 a.m. to the dialysis center and returned to the facility at 4:30 p.m. Resident #21 revealed the facility provided a sandwich, juice and cookies in a plastic bag. The resident stated that on 9/23/19, she received a scrambled egg in a plastic sandwich bag which was placed in her small suitcase, next to the blanket she carried to dialysis. She stated that upon arrival to the dialysis center, the plastic bags of residents' lunches were not placed in a refrigerator. The resident revealed she discarded the egg sandwich the facility provided in the trash at the dialysis center.