| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| GREENDALE FOREST NURSING AND REHABILITATION CENTER | 1304 SE SECOND STREET SNOW HILL, NC 28580 |

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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on Sept 30, 2019 through October 4, 2019. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Prepardness (event ID D3QP11). | E 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the | F 550 | | 11/1/19 |

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

Electronically Signed | 10/28/2019

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| F 550 | Continued From page 1<br>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and interviews, the facility failed to assist the resident with feeding when the meal tray was delivered to the room in 1 of 1 resident observed who required assistance with feeding.(Resident #20)<br><br>Findings Included:<br><br>Resident (#20) had resided at the facility since 08/04/2008 and recently began Hospice services on 7/9/2019. The resident's (#20) current diagnoses included advanced non-Alzheimer's dementia, cerebral infarction (stroke), encephalopathy, hyperosmolality, hypernatremia, urinary tract infection and sepsis.<br><br>A review of the physician orders for the resident (#20) dated 7/9/2019 revealed a hospice service order and a diet order for a regular diet with pureed texture.<br><br>The most recent minimum data set (MDS) assessment dated 07/15/2019 revealed resident (#20) was nonverbal and severely cognitively impaired. The MDS further revealed the resident (#20) was totally dependent for all activities of daily living including eating and required a | F 550 | F 550<br><br>Resident #20 received assistance with feeding on 10-1-2019 under the supervision of the RN Supervisor (RNS) or Staff Facilitator (SF), or Quality Assurance (QA).<br><br>100% audit of all residents requiring assistance with feeding to include resident #20 was initiated on 10-23-2019 by the RNS or SF or QA utilizing a resident care audit tool to ensure that the resident was provided feeding assistance per the resident care guide. All areas of concerns will be addressed during the audit. Audit to be completed by 11-1-2019.<br><br>100% in-service was initiated by the Staff Facilitator on 10-4-2019 in regards to: When passing trays, the trays for residents who require assistance with feeding must remain on tray cart until a staff member can provide feeding assistance. The staff member must provide feeding assistance at the time tray is brought in the room. Do not leave tray | |

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| F 550 | Continued From page 2<br>mechanical altered diet.<br><br>The resident's (#20) care plan dated 7/24/2019 revealed interventions to assist with meals in nutrition, activities of daily living, and the resident care guide.<br><br>The dietary note dated 9/25/2019 revealed the resident (#20) required total assistance with eating a general mechanical altered pureed diet.<br><br>A continuous observation on 10/1/2019 noted a nurse aide delivered a breakfast tray to the resident's (#20) room at 8:24am. The tray was placed on the overbed table located across the room. The nurse aide turned the lights on and exited the room. At 8:40am the meal tray remained on the overbed table; a nurse aide entered the room and addressed the resident (#20), pulled the curtain closed, turned off the light, and exited the room. At 8:55am, the administrator entered the room of the resident (#20) and removed the meal tray from the room. The administrator addressed a nurse aide in the hall and returned to the room of the resident (#20) with the meal tray and a nurse aide. The meal tray was placed on the overbed table across the room, lights were turned on, and the administrator and the nurse aide (#2) exited the room. At 8:58am, a nurse aide (#2) entered the room, addressed the resident (#20) by name, and informed the resident (#20) she would be feeding her breakfast. The nurse aide (#2) prepared the resident (#20) for the meal and offered the first spoonful at 9:02am. The resident (#20) willingly and eagerly opened her mouth wide to accept the food on the spoon and drank liquids through a straw. The resident was noted to shake her head when offered a spoonful of food and was not | F 550 | sitting in resident room. In-service to be completed by 11-1-2019.<br><br>10% of all residents requiring assistance with feeding to include resident #20 will be audited by the RNS or SF or QA utilizing a resident care audit tool weekly x 8 weeks and monthly x 1 month to ensure all residents requiring assistance received assistance with feeding per the resident care guide. Any identified areas of concerns will be addressed by the RNS or SF or QA during the audit. The Director of Nursing (DON) will review and initial the resident care audit tool weekly x 8 weeks and monthly x 1 month to ensure completion and all areas of concern were addressed.<br><br>The DON will forward the results of the Resident Care Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Resident Care Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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| F 550 | Continued From page 3 | F 550 | | |

ready for another spoonful at the time. The resident consumed 50% of the meal.

An observation of the lunch meal in the dining room on 10/1/2019 revealed the resident (#20) eagerly and willingly opened the mouth and raised her head toward the approaching food on the spoon.

During an observation on 10/2/2019 at 08:40am, a nurse aide delivered the meal tray and remained in the room and fed the resident (#20). The resident (#20) was observed opening her mouth willingly to accept food as the food approached the mouth.

An interview with the nurse aide (#2) on 10/04/2019 revealed meal trays were delivered to the dining room residents first; then the remaining trays were passed out on the hall. The nurse aide (#2) stated nurse aides assisted the residents with feeding as staff came available which was within five minutes; and if longer, the nurse aide tested the food for warmth before feeding the resident.

In an interview with the nurse (#2) on 10/4/2019, the nurse (#2) noted the delivery of meal trays to the residents started with residents in the dining room, then meal trays were delivered to the residents that needed assistance setting up the trays, and the last meal trays delivered were to the residents that needed assistance with feeding. The nurse (#2) stated the nurse aide would not know how long a tray had been in the room prior to feeding a resident, but staff tried to feed the residents as soon as possible.

An interview with the director of nursing (DON) on

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| F 550 | Continued From page 4<br>10/4/2019 revealed meal trays delivered to rooms uncovered stayed warm and meal trays placed to the side eliminated residents smelling the food while waiting for feeding assistance. The DON stated staff were to assist the residents with feeding when staff entered the room and saw a meal tray that needed to be fed to a resident. The DON further estimated no more than thirty minutes as a reasonable time for a resident to wait for assistance to be fed.<br><br>During an interview with the administrator on 10/4/2019, the administrator admitted he removed the meal tray on 10/1/2019 because he did not know if the resident refused the meal tray or when the meal tray was delivered. The administrator stated the nurse aide who entered the room after him should had assisted the resident with feeding. | F 550 | | |
| 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 | F 657 | | 11/1/19 |

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| F 657 | Continued From page 5<br>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 resident and staff interviews and record reviews, the facility failed to invite a resident or resident's representative to participate in care planning for 2 of 4 residents investigated for care planning (Residents #7and #41).<br><br>Findings included:<br><br>1.A review of the medical record revealed Resident #7 was admitted 12/12/2018 with diagnoses including paraplegia, indwelling urinary catheter related to neurogenic bladder and tracheostomy.<br>The Quarterly Minimum Data Set (MDS) dated 6/25/2019 noted Resident #7 was cognitively intact and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the help of one person.<br><br>In an interview on 10/1/2019 at 3:37 PM, Resident #7 stated "I did not even know we had care plan meetings" and she did not remember anyone inviting her or telling her anything about a care plan meeting.<br><br>On 10/2/2019 at 2:15 PM, the facility Social | F 657 | F 657<br><br>On 10-25-2019, Resident #7 and/or Resident Representative (RR) were invited by the Administrator to attend a resident care plan meeting with documentation in the progress note. On 10-25-2019, Resident #41 and/or Resident Representative (RR) were invited by the Administrator to attend a resident care plan meeting with documentation in the progress note. The care plan meeting for resident #7 was held on 10-28-2019. The care plan meeting for resident #41 was held on 10-28-2019.<br><br>A 100% audit of all current residents was initiated on 10-25-2019 by the MDS Nurse or designee utilizing a resident census (to include residents #7 and #41) to ensure that resident and/or RR was invited to participate in the resident care plan meeting with documentation in progress note. Any identified areas of concerns will be addressed by the MDS Nurse or | |

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| F 657 | Continued From page 6<br>Worker (SW) stated the Admissions Coordinator sent out notices of new admissions and the Social Worker will arrange care planning with everyone involved, including the resident and their family or Responsible Party (RP). The Social Worker indicated the care planning usually involves the Rehab Manager, the Social Worker, the Activities Director, the Dietary Manager, the hall nurse for the resident's hall and the Nursing Assistant.<br><br>The MDS coordinator was interviewed on 10/2/2019 at 3:50 PM and stated she fills out the sheet to note which residents need a care plan review or revision. This sheet is put into the Social Worker's mailbox. The MDS coordinator also attempted to locate documentation of care planning for Resident #7 in her files and in the electronic health record but was unable to locate any documentation.<br><br>On 10/2/2019 at 4:15 PM, in an interview, the Social Worker stated she did not keep copies of invitations to care plan meetings. The Social Worker indicated she personally invited the residents to participate their care planning but was unable to provide documentation of the invitations.<br><br>In an interview on 10/3/2019 at 10:55 AM, the Director of Nursing stated her expectations were residents and families or RPs would be notified of the care planning, and there would be documentation of the notification.<br><br>On 10/4/2019 at 11:55 AM, in an interview, the facility Administrator stated his expectation was care planning would be held as required by regulation. | F 657 | designee during the audit to include scheduling a care plan meeting. The audit will be completed on 11-1-2019.<br><br>An in-service was initiated on 10-2-2019 by the Administrator with the Social Worker (SW), the Admission Director and the Accounts Receivable Director and will be completed by 11-1-2019 in regard to inviting the resident and/or RR to the care plan meeting with documentation in the progress notes.<br><br>10% of all current residents due for care plan meetings in that period (to include residents #7 and #41) will be audited by the Accounts Receivable Director or designee weekly x 8 weeks and monthly x 1 month, utilizing a Care Plan Meeting Audit tool to ensure that residents and/or RR's are invited to participate in the care plan meeting with documentation in the progress notes. All identified areas of concerns will be corrected during the audit. The Administrator will review and initial the Care Plan Meeting Audit tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns have been addressed.<br><br>The Administrator will forward the results of the Care Plan Meeting Audit tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Meeting Audit tool to determine trends and/or issues that might need further interventions put into place and to determine the need for further and/or | |

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| F 657 | Continued From page 7<br><br>2.A review of the medical record revealed Resident #41 was admitted 2/20/2019 with diagnoses of Multiple Sclerosis and neurogenic bladder.<br><br>The Admission Minimum Data Set (MDS) dated 2/26/2019 noted Resident #41 was cognitively intact and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the help of one person.<br><br>In an interview on 10/1/2019 at 9:13 AM, Resident #41 stated she did not remember being invited to a care plan meeting.<br><br>A review of progress notes revealed Resident #41 had a care plan meeting on 2/26/2019 and the Resident was present. There was no documentation of any further care planning.<br><br>On 10/2/2019 at 2:15 PM, the Social Worker was interviewed and stated a notice was sent to her from the Admissions Coordinator when there was a new admission and she arranged a care plan meeting. The Social Worker indicated the residents were invited and invitations were also sent to the resident's family or Responsible Party (RP) and the care plan meeting was arranged. The Social Worker stated care planning usually involved the Rehab Manager, the Dietary Manager, the Activities Director, the nurse from the resident's hall, the Nursing Assistant and the Social Worker.<br><br>In an interview on 10/2/2019 at 3:50 PM, the MDS Coordinator stated she fills out the sheet to note which residents need a care planning and sends it to the Social Worker via her mailbox. The MDS | F 657 | frequency of monitoring. | |

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| F 657 | Continued From page 8<br>Nurse attempted to locate care planning notes regarding Resident #41, in her files and in the electronic health record in several places but was unable to locate that information.<br><br>On 10/2/2019 at 4:15 PM, in an interview, the Social Worker stated she did not retain copies of care plan meeting invitations. The Social Worker noted she personally invited the residents but did not have documentation.<br><br>In an interview with the Director of Nursing on 10/3/2019 at 10:55 AM, she stated her expectation was families and residents were invited and there would be documentation of the notification.<br><br>On 10/3/2019 at 11:55 AM in an interview, the facility Administrator stated his expectation was care plan meetings would be held as required by regulation. | F 657 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and resident and staff interviews, the facility failed to perform range of motion exercises and apply | F 684 | F 684<br><br>On 10-23-2019, resident #91's Range of | 11/1/19 |

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| F 684 | Continued From page 9<br>splints to prevent contractures in 2 of 2 residents receiving restorative care as ordered. (Resdients #91, #26)<br><br>Findings included:<br><br>1. Resident (#91) was admitted to the facility on 03/30/2017 with diabetes mellitus type II, quadriplegia, cervical 5-7 incomplete injury, muscle weakness, stiffness of joint, hypokalemia, hypomagnesemia, and anemia.<br><br>The care plan for resident (#91) revised on 10/22/2018 identified resident (#91) at risk for further contractures bilaterally in the upper extremities. Interventions included to monitor both upper extremity splints for pain and skin irritation, to apply a right resting hand splint every morning and removed every evening, and to apply a left resting hand splint at night and remove every morning. The care plan further noted for restorative nurse aides to document the reason if resident (#91) did not participate in the restorative stretching exercises.<br><br>The minimum data set (MDS) assessment dated 1/11/2019 revealed resident (#91) was cognitively intact with impairments to both upper extremities. Resident (#91) required extensive assistance with all activities of daily living except for feeding, resident (#91) was able to feed self.<br><br>A review of the physician orders dated 01/28/2019 revealed an order for a left resting hand splint every day in the evening and right resting hand splint every day and evening shift.<br><br>A review of the nursing training sheet dated and signed by staff on 9/12/2019 revealed | F 684 | Motion (ROM) was performed and the splint was applied by the restorative aide per the resident's plan of care. On 10-23-2019, resident #26's ROM was performed and the splint was applied by the restorative aide per resident's plan or care.<br><br>A 100% audit was initiated on 10-23-2019 by the Director of Nursing (DON) to ensure that all residents requiring splints to include resident #91 and #26 splints were applied per restorative plan of care to prevent further contractures or worsening of current contracture. All identified areas of concerns will be addressed to include application of splint. Audit to be completed by 11-1-2019.<br><br>A 100% audit was initiated on 10-23-2019 by the DON to ensure all residents requiring ROM to include residents #91 and #26 received ROM as scheduled per the restorative plan of care to prevent further contractures or worsening of current contracture. All identified areas of concerns will be addressed to include performing ROM. Audit to be completed by 11-1-2019.<br><br>An in-service was initiated on 10-4-2019 by the Staff Facilitator with nursing staff in regard to performing ROM and applying splints per the resident restorative plan of care. In-service to be completed by 11-1-2019.<br><br>10% of all residents requiring ROM and/or splints, to include residents #91 and #26 | |

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| F 684 | Continued From page 10<br>occupational therapy ended on 09/17/2019 and nursing restorative care started on 09/18/2019. Restorative care instructions required staff to provide passive range of motion and prolonged stretch to the right fingers and wrist prior to the application of the right resting hand splint. The right hand splint was to be worn five times a week for 6 to 8 hours with no discomfort.<br><br>A review of the restorative nursing notes dated 9/18/2019 to 10/3/2019 revealed resident (#91) received no passive range of motion or splint application and no refusal of care was documented. Restorative stretching exercises occurred for 15 minutes 5 out of the 16 days.<br><br>A review of the daily staffing shift assignment sheet dated 10/03/2019 posted a restorative care nurse aide worked on that day. A further review of the daily shift assignment sheets from 9/19/2019 to 10/2/2019 revealed one restorative nurse aide was scheduled 6 out of 14 days.<br><br>An observation on 9/30/2019 at 3:40pm revealed no right hand splint on the resident (#91).<br><br>The resident (#91) was observed on 10/1/2019 at 12:58pm without the right hand splint on.<br><br>An observation on 10/2/2019 at 8:45am and at 5:00pm revealed no right hand splint on resident (#91).<br><br>An observation on 10/03/2019 at 6:21am revealed a left wrist splint on the resident (#91) while sleeping.<br><br>An observation on 10/04/2019 at 9:11am revealed no right hand splint on the resident (#91). | F 684 | will be audited by the RNS or SF or QA utilizing a ROM and Splint audit tool weekly x 8 weeks and monthly x 1 month to ensure that ROM and splinting is performed per the restorative plan of care. Any identified areas of concerns will be corrected by the RNS or SF or QA during the audit to include performing ROM and/or applying splint. The Director of Nursing (DON) will review and initial the ROM and Splint audit tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were corrected.<br><br>The DON will forward the results of the ROM and Splint Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the ROM and Splint Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |

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During an interview with resident (#91) on 09/30/2019, the resident (#91) revealed a splint was worn to the left hand at night and a splint for the right hand was worn during the day. Resident (#91) noted the splint was applied when staff were asked, but when neck spasms occurred, having the splint on the right hand was not something the resident thought about asking for.

An interview with nurse aide (#3) on 10/3/2019 revealed the restorative aide applied the splint to resident (#91) in the morning and took the splint off in the evening before end of shift. Nurse aide (#3) further stated nurse aides that have been trained to apply splints and the nurses could perform the exercises and apply the splints and had access to document care on the restorative sheet in the computer.

An interview with the restorative nurse aide on 10/3/2019 at 3:10pm revealed census decided if there were one or two restorative aides assigned restorative duties daily and under the splint icon in restorative care on the computer listed all the residents needing splints and exercises. The restorative nurse aide noted resident (#91) had exercise and the splint applied at 2:00pm on 10/3/2019. The restorative nurse aide further noted the nurse aide or nurse on the hall were informed when there was no restorative nurse aide for a day and stated nurses could put splints on residents.

An interview with the nurse (#4) on 10/3/2019 at 4:57pm revealed the application of the splints was in the care guide and nurses could apply the splints. Nurse (#4) also noted if the resident refused exercises or splints, the restorative nurse

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aide informed the nurses.

During an interview with resident (#91) on 10/4/2019 at 9:11am, the resident (#91) admitted to wearing the right hand splint on 10/3/2019 and 10/1/2019 for a short time. The resident noted how long the splint is worn depends on when the splint is applied and how the resident (#91) feels. Resident (#91) noted pain in her neck sometimes allowed the resident (#91) not to think about whether the right hand splint and exercises had been performed that day. Resident (#91) admitted not being able to wear the splint during physical therapy but asked for the splint because the right wrist would contract and hurt. Resident (#91) noted without the right splint to straighten the right wrist, the right wrist would contract again.

An interview with the nurse (#3) on 10/4/2019 revealed resident (#91) wore the splint after lunch usually and if restorative nurse aide didn't apply, the nurse aide or the nurse would apply the splint. An interview with the director of nursing on 10/4/2019 revealed the facility was staff with two restorative nurse aides and no restorative nurse. The DON explained the restorative nurse aides received training from the therapist on exercises and application of a splint for each resident receiving restorative care. The DON admitted restorative nurse aides were staffed daily including weekends and had recently pulled restorative nurse aides to staff the facility but tried to keep one restorative nurse aide on the assignment. The DON further noted when restorative nurse aides staffed the facility, the restorative nurse aide was expected to communicate with the nurse aide and nurse the residents listed for restorative care. The DON

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further noted all nurse aides and nurses had access to documentation of restorative care on the computer.

2. Resident (#26) has resided in the facility since 01/30/15 and the last admission was dated 7/18/2019 with diabetes mellitus, hyperlipidemia, hypertension, neurogenic bladder, quadriplegia, and a seizure disorder listed as current diagnoses.

A review of the rehab communication to nursing sheet dated and signed on 06/19/2019 revealed occupational therapy ended on 06/19/2019 and restorative care began on 06/20/2019. Restorative care instructions required staff to provide the resident with passive range of motion to the left upper extremity that included 2 sets of 10 repetitions in flexion and abduction of the shoulder and extension of the elbow. The left upper extremity splint was to be applied for 6 hours and check for redness or skin breakdown upon removal of the splint.

The care plan dated 6/21/2019 for resident (#26) revealed resident (#26) was at risk for decrease range of motion in the left upper extremity. Interventions included application of the left upper extremity elbow extension splint for 6 hours a day 5 days a week, performing passive range of motion to the shoulder and elbow, documentation of the reason if resident (#26) did not participate in the splint and brace program, and monitoring pain, the skin integrity under the splint or brace daily, and for a decrease in range of motion.

The minimum data set (MDS) assessment dated

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7/19/2019 revealed resident (#26) to be cognitively intact and required extensive to total assistance with activities of daily living except with eating. Resident (#26) required the tray to be set up but was able to feed self. The MDS further revealed the resident (#26) had upper and lower extremity impairments.

A review of the restorative nursing notes dated 9/18/2019 to 10/3/2019 revealed resident (#26) received passive range of motion 5 out of 16 days and the splint was applied 4 out of 16 days.

A review of the daily staffing shift assignment sheet dated 10/03/2019 posted a restorative care nurse aide worked on that day. A further review of the daily shift assignment sheets from 9/19/2019 to 10/2/2019 revealed one restorative nurse aide was scheduled 6 out of 14 days.

An observation on 9/30/2019 revealed the splint for resident's (#26) left elbow was laying on top of the bedside table.

The splint for resident (#26) was observed on 10/2/2019 on the bedside table on top of a pillow. The left arm of the resident (#26) was noted to be flexed across the stomach area.

An observation on 10/3/2019 at 3:00pm revealed resident's (#26) arm splint was not located on the bedside table or on the left elbow. The left hand of the resident (#26) rested on the stomach area causing the left elbow to be flexed.

Resident (#26) was observed on 10/4/2019 at 9:06am with the arm splint to the left elbow.

Interviews with the resident (#26) on 9/30/2019

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revealed the resident (#26) had limited movement to the left elbow and was to wear the left elbow splint daily. Resident (#26) admitted not able to recall if staff offered to put the splint on that day. On 10/2/2019 at 1:25pm, resident (#26) revealed the left splint had not been applied and had ask the staff for the splint to be applied. On 10/3/2019 at 3:00pm, resident (#26) stated no one had been in the room to exercise or apply the left arm splint that day or the last 4 days. The resident (#26) revealed the splint was used to help keep the left arm straight.

An interview with nurse aide (#3) on 10/3/2019 revealed nurse aides that had been trained to apply splints and nurses could perform the exercises and splints and had access to document care on the restorative sheet in the computer.

An interview with the restorative nurse aide on 10/3/2019 at 3:10pm revealed census decided if there were one or two restorative aides assigned restorative duties daily and under the splint icon in restorative care on the computer listed all the residents needing splints and exercises. Resident (#26) was listed and documented as not done. The restorative nurse aide stated, "I forgot to do resident (#26) today." The restorative nurse aide noted the nurse aide or nurse on the hall were informed when there is no restorative nurse aide for the day. The restorative stated nurses can put the splints on.

An interview with the nurse (#4) on 10/3/2019 at 4:57pm revealed resident (#26) used a trapeze bar to reposition oneself up in the bed and the restorative nurse aides cared for the splints. The nurse (#4) admitted application of the splints was

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| F 684 | Continued From page 16<br>in the care guide and nurses could apply the splints. Nurse (#4) also noted if the residents refused exercises or splints, the restorative nurse aide informed the nurses. Nurse (#4) stated she was not aware the resident refused to wear the splint and if the splint was not on during the evening shift, nurse (#4) assumed the splint had been applied on the day shift.<br><br>An interview with the director of nursing on 10/4/2019 revealed the facility was staffed with two restorative nurse aides and no restorative nurse. The DON explained the restorative nurse aides received training from the therapist on exercises and application of a splint for each resident receiving restorative care. The DON admitted restorative nurse aides were staffed daily including weekends and had recently pulled restorative nurse aides to staff the facility but tried to keep one restorative nurse aide on the assignment. The DON further noted when restorative nurse aides staffed the facility, the restorative nurse aide was expected to communicate with the nurse aide and nurse the residents listed for restorative care. The DON further noted all nurse aides and nurses had access to documentation of restorative care on the computer. | F 684 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. | F 690 | | 11/1/19 |

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| F 690 | Continued From page 17<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and resident interviews and record review, the facility failed to secure an indwelling urinary catheter to prevent tension for one of one resident reviewed for indwelling urinary catheters (Resident #7).<br>Findings included:<br>A review of the medical record revealed Resident #7 was admitted 12/12/2018 with diagnoses that included neurogenic bladder.<br>The Annual Minimum Data Set (MDS) dated | F 690 | F 690<br><br>On 10-3-2019, resident #7's suprapubic catheter was secured with an anchoring device per the care plan by the RNS or SF or QA (spell out who).<br><br>A 100% audit was initiated on 10-3-2019 by the RNS or SF or QA of all residents (to include resident #7) with indwelling | |

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| F 690 | Continued From page 18<br>9/26/2019 noted Resident #7 to be cognitively intact and needed extensive to total assistance for all care with the help of one to two persons.<br>The Care Area Assessment noted a focus of indwelling catheter and this area went to care plan.<br>The care plan dated 12/21/2018 noted a focus of altered pattern of urinary elimination with indwelling catheter (suprapubic). At risk for infection related to impaired mobility and diagnosis of neurogenic bladder. The goal was resident will be free from urinary tract infection through next evaluation. Interventions included: Ensure that drainage tubing is secured with anchoring device, i.e., leg strap, to prevent tension or accidental removal.<br>An order was written on 9/8/2019 for catheter leg strap check every day and when necessary. The leg strap check was located on the Treatment Administration Record (TAR).<br>A review of the TAR revealed on 9/30, 10/1 and 10/2/2019 the leg strap check was initialed as being in place.<br>On 9/30/2019 at 2:00 PM, Resident #7 stated she did not have a leg strap for the catheter tubing.<br>On 10/1/2019 at 3:41 PM, Resident #7 was interviewed and stated she had a leg strap at some time in the past and it came off and was not replaced.<br>On 10/2/2019 at 11:30 AM Resident #7 stated she did not have a leg strap and it had been weeks since she had a leg strap for the catheter tubing.<br>On 10/3/2019 at 10:30 AM an observation of catheter care was made when Nurse #1 cleaned the suprapubic catheter. There was a leg strap in place and Nurse #1 stated she had put the strap on that morning.<br>Nursing Assistant (NA) #1 was interviewed on | F 690 | urinary catheters and/or suprapubic catheters utilizing a resident census to ensure that the indwelling urinary catheters and/or suprapubic catheters were secured with an anchoring device per the care plan. Any identified areas of concerns will be corrected during the audit to include securing the indwelling urinary catheters and/or suprapubic catheters with an anchoring device. Audit to be completed 11-1-2019.<br><br>A 100% in-service was initiated on 10-3-2019 by the Staff facilitator with all nurses and nursing assistants in regard to: must follow care plan regarding leg strap application. In-servicing to be completed 11-1-2019.<br><br>10% of all residents requiring an indwelling urinary catheter and/or a suprapubic catheter (to include resident #7) will be audited by the RNS or SF or QA utilizing Catheter Monitoring Tool weekly x 8 weeks and monthly x 1 month to ensure that the indwelling urinary catheter and/or suprapubic catheter are secured with an anchoring device per the care plan. All areas of concerns will be corrected by the RNS or SF or QA during the audit. The Director of Nursing (DON) will review and sign the Catheter Monitoring tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed.<br><br>The DON will forward the results of the Catheter Monitoring Tool to the Executive | |

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| F 690 | Continued From page 19<br>10/3/2019 at 2:00 PM and stated Resident #7 was usually on her assignment and bathing her was part of that assignment. NA #1 stated she did not remember if Resident #7 was wearing a leg strap for the past few weeks. NA #1 indicated she would inform the nurse if she noticed a leg strap was missing.<br>In an interview on 10/3/2019 at 3:39 PM, the Treatment Nurse stated she and the NAs were responsible for checking the leg strap was in place on Resident #7. The treatment nurse stated she did not know why the leg strap check on the TAR was initialed as being checked on 9/30, 10/1 and 10/2/2019, when there was no leg strap in place until 10/3/2019. The Treatment Nurse stated sometimes, when she went to check, Resident #7 was already up and had her pants on and she could not check the strap.<br>On 10/3/2019 at 3:57 PM, in an interview, the Director of Nursing (DON) stated Resident #7 told staff that she could not feel the leg strap and Resident #7 had a large bowel movement on 10/1/2019, and the DON wondered if the strap had come off at that time. The DON indicated she did not know why the leg strap was checked as being present on 9/30/19 and 10/2/2019 and was not on.<br>In an interview on 10/4/2019 at 11:58 AM, the DON stated her expectation was the catheter tubing leg strap would be applied for any resident who had an indwelling catheter, and a Nursing Assistant who noted no leg strap would notify a nurse. | F 690 | QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Catheter Monitoring Tool to determine trends and/or issues that might need further interventions put into place and to determine the need for further and/or frequency of monitoring. | |