STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	C 03/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		4/20/14

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

Electronically Signed | 04/18/2014

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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to report 1 of 1 allegation of staff to resident abuse allegations to the State Agency within 24 hours of discovery and failed to report the investigative findings in 1 of 1 allegation of staff to resident abuse to the State Agency within 5 working days of discovery for 1 of 3 residents reviewed for abuse (Resident #2). The findings included: Resident #2 was admitted to the facility on 7/1/13 with medical diagnoses which included osteoarthrosis and hypertension. The most recent Minimum Data Set (MDS) dated 2/27/14 documented the resident was moderately cognitively impaired. The MDS further documented the resident had no signs of delirium or behavior problems for the last three months. The MDS also documented the resident was totally dependent on staff for dressing, toileting and personal hygiene. The same assessment further revealed the resident required extensive assistance with transfers. During an interview on 3/22/14 at 11:14 am, Resident #2 stated NA #1 gave her a good beating on March 7, 2014. The resident further indicated NA#1 was strong and would not stop hitting her. She stated the NA was upset about something. Resident #2 further revealed she told NA#1 that she was hurting her but she would not stop hitting her. She stated her left arm was already hurting but now she is really sore in the area of her left shoulder since she was beaten. Resident #2 stated she told Nurse #3 that was on	F 225	Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental	

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F 225	Continued From page 2 duty at the time about how NA#3 had beaten her. She further revealed that she told her responsible party about the incident the next day during her visit to the facility. On 3/23/14 at 9:48 am during an interview, Resident #2's responsible party stated while visiting with the resident on Saturday March 8, 2014, the resident informed her that she had been beaten by NA #1. The responsible party further indicated she then went and spoke with NA#3 who was on duty and informed her of the allegation made by the resident that she had been beaten by NA #1 on the day before. She further stated Resident #2 may be elderly but she was sharp in the mind. In an interview on 3/23/14 at 11:00am, NA#1 stated she was responding to Resident #2's call light when she went to her room. She further stated after she transferred the resident to the bed, Resident #2 stated "You didn't have to treat me like a rag doll." She further stated the resident began crying, accused her of abusing her and told her to get out of her room. NA#1 stated she immediately left the resident's room and went to the nurses station and informed Nurse #3 that the resident accused her of abusing her and that the resident was crying. NA #1 further indicated she informed Nurse #3 that the resident had asked her to leave her room and she had left the resident uncovered. On 3/23/13 at 11:38 am during a phone interview, Nurse #3 stated she was informed by NA#1 that the resident became combative and threw the NA out of her room on March 7, 2014. She further stated she went to the resident's room and the resident informed her that she did not like NA #1	F 225	Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. F225 It is the facility's intent and normal practices to ensure that all allegations of mistreatment, neglect, and abuse of residents and the misappropriation of their property are reported through established procedures in accordance with state law. The facility endeavors to ensure allegations are reported timely and are thoroughly investigated. The facility has written policies and procedures designed to maintain these goals. Training on how to follow these policies and procedures is one of many components covered during orientation and through routine training. It□s the facility□s practice to ensure all new staff is instructed regarding allegation reporting practices. Orientation records, checklists, file audits, observations, routine training, audits, resident council meetings, family satisfaction reviews, medical director reviews, consultant reviews and various quality assurance measures are examples of the many components utilized. Upon review of the facility records, an investigation was initially started on the day of the allegation identified. Although the allegation was investigated and findings reported to the state agency, the portion of the policy regarding timing of administrator reporting and initial agency	

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F 225	Continued From page 3 and that she had hurt her arms putting her to bed. Nurse #3 stated she could not see any injuries to the resident's arms and her range of motion was good. She further indicated it was her nursing decision that it was a simple misunderstanding between the resident and the NA and that she did not consider it abuse. She further indicated the resident was normally reliable. During an interview on 3/24/14 at 3:40 pm, NA #3 stated the resident's responsible party came up to her on Saturday March 8, 2014 around dinner time and advised her that the resident stated she had been hit by NA#1 on the day before. NA#3 further stated she told the responsible party that she might want to talk with someone else because she did not know anything about it. She further revealed she did not work on Friday March 7, 2014. NA#3 further indicated she did not tell her nurse that was working at the time because she didn't think the nurse would know anything about the incident. On 3/25/14 at 8:38 am in an interview, Nurse #4 stated he was told by Nurse #3 during the 3pm-11pm to 11pm-7am shift exchange on 3/7/14 that there was an incident involving Resident #2. He further stated Nurse #3 stated the resident had reported that NA#1 had hit her. Nurse #4 stated he was told by the same nurse that the incident had already been reported. He further stated Resident #2 was usually reliable and friendly with staff. A review of the facility documentation revealed the 24 hour report was completed on 3/11/14 at 11:04 am and the 5 day report was completed on 3/18/14 at 5:55 pm. Further review of the facility documentation revealed a revised first sheet of	F 225	reporting was outside of guidelines. The omission occurred due to a misinterpretation of the policy by Nurse #3. The reporting omission was identified and being addressed through the QAA process prior to the survey on 03/22/14. Corrective Action The Social Service Director (SSD) and the Director of Nursing (DoN) conducted on 03/11/14 - 03/18/14 a thorough investigation and reported the findings to the state agency. The SSD has conducted follow-up interviews with the identified resident. Resident stated that everything (is) going good; I□m getting along fine; no problems with any staff. Identification of Others A review was conducted by the SSD and administrative staff the week of 03/11/14 to ensure that no other reporting/findings omissions had occurred. No other resident affected. Measures Nurse #3 was verbally counseled on 03/14/14 regarding the misinterpretation. Clinical nurses and CNA's received instructions on reporting/investigation of resident allegations. The Administrator or DoN will ensure that any future allegations will be reported with findings to the appropriate agency per policy. Monitor As an ongoing QAA process, facility staff	

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F 225	Continued From page 4 the 5 day report was submitted on 3/19/14 at 2:22 pm. The alleged incident occurred on march 7, 2014. During an interview on 3/25/14 at 5:25 pm, the Director of Nursing revealed it was her expectation for the staff to notify her or the administrator of any allegation of abuse immediately.	F 225	is being re-trained by Staff Development Coordinator or their designees regarding investigation/reporting of resident allegations. Additionally, the SSD will interview residents during 1:1 visits and at monthly resident council meetings. The Administrator will monitor allegation investigations and agency reporting. The DoN will report findings to the Quality Assessment and Assurance (QAA) Committee monthly for 3 months. The findings will be provided to the QAA committee regarding the April, May and June monitoring. Date of Completion: 04/20/14	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to implement their policies and procedures to identify, protect, investigate and report an allegation of abuse for 1 of 3 residents (Resident #2) reviewed for abuse. The findings included: Facility policy titled "ABUSE POLICY" undated	F 226	F226 It is the facility's intent and normal practices to ensure that all allegations of mistreatment, neglect, and abuse of residents and the misappropriation of their property are investigated through established procedures in accordance with state law. The facility endeavors to ensure allegations are reported timely and	4/20/14

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F 226	Continued From page 5 documented the staff would be trained concerning abuse and neglect during his/her initial orientation and at least annually thereafter. Training would include definitions and examples of abuse, neglect, isolation and misappropriation of residents' items/money and that there is no retribution for reporting any actual or possible abuse or neglect. The policy further documented "Alleged incidents, including injuries of unknown origin, abuse, neglect, isolation, and misappropriation of a resident 's items or money are investigated promptly and thoroughly." Resident #2 was admitted to the facility on 7/1/13 with medical diagnoses which included osteoarthrosis and hypertension. The most recent Minimum Data Set (MDS) dated 2/27/14 revealed the resident had no signs of delirium or behavior problems for the last three months. The MDS also documented the resident was totally dependent on staff for dressing, toileting and personal hygiene. The same assessment further revealed the resident required extensive assistance with transfers. During an interview on 3/22/14 at 11:14 am, Resident #2 stated NA #1 gave her a good beating on March 7, 2014. The resident further indicated NA#1 was strong and would not stop hitting her. She stated the NA was upset about something. Resident #2 further revealed she told NA#1 that she was hurting her but she would not stop hitting her. She stated her left arm was already hurting but now she is really sore in the area of her left shoulder since she was beaten. Resident #2 stated she told Nurse #3 that was on duty at the time about how NA#3 had beaten her. She further revealed that she told her responsible party about the incident the next day during her	F 226	are thoroughly investigated. The facility has written policies and procedures designed to maintain these goals. Training on how to follow these policies and procedures is one of many components covered during orientation and through routine training. It□s the facility□s practice to ensure all new staff is instructed regarding allegation reporting practices. Orientation records, checklists, file audits, observations, routine training, audits, resident council meetings, family satisfaction reviews, medical director reviews, consultant reviews and various quality assurance measures are examples of the many components utilized. Upon review of the facility records, an investigation was initially started on the day of the allegation identified. Although the allegation was investigated and findings reported to the state agency, the portion of the policy regarding timing of administrator reporting and initial agency reporting was outside of guidelines. The omission occurred due to a misinterpretation of the policy by Nurse #3. The reporting omission was identified and being addressed through the QAA process prior to the survey on 03/22/14. Corrective Action The Social Service Director (SSD) and the Director of Nursing (DoN) conducted on 03/11/14 - 03/18/14 a thorough investigation and reported to the state agency. Interventions were implemented during the investigation to protect the resident.	

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F 226	Continued From page 6 visit to the facility. On 3/23/14 at 9:48 am during an interview, Resident #2's responsible party stated while visiting with the resident on Saturday March 8, 2014, the resident informed her that she had been beaten by NA #1. The responsible party further indicated she then went and spoke with NA#3 who was on duty and informed her of the allegation made by the resident that she had been beaten by NA #1 on the day before. She further stated Resident #2 may be elderly but she was sharp in the mind. In an interview on 3/23/14 at 11:00am, NA#1 stated she was responding to Resident #2's call light when she went to her room. She further stated after she transferred the resident to the bed, Resident #2 stated "You didn't have to treat me like a rag doll." She further stated the resident began crying, accused her of abusing her and told her to get out of her room. NA#1 stated she immediately left the resident's room and went and informed Nurse #3 that the resident accused her of abusing her and was crying. NA #1 further indicated she informed Nurse #3 that the resident had asked her to leave her room and she had left the resident uncovered. On 3/23/13 at 11:38 am during a phone interview, Nurse #3 stated she was informed by NA#1 that the resident became combative and threw the NA out of her room on March 7, 2014. She further stated she went to the resident's room and the resident informed her that she did not like NA #1 and that she had hurt her arms putting her to bed. Nurse #3 stated she could not see any injuries to the resident's arms and her range of motion was	F 226	The SSD has conducted follow-up interviews with the identified resident. Resident stated that everything (is) going good; I□m getting along fine; no problems with any staff. Identification of Others A review was conducted by the SSD and administrative staff the week of 03/11/14 to ensure that no other reporting/findings omissions had occurred. No other resident affected. Measures Nurse #3 was verbally counseled on 03/14/14 regarding the misinterpretation. Clinical nurses received instructions on reporting/investigation of resident allegations. The Administrator or DoN will ensure that any future allegations will be reported with findings to the appropriate agency per policy. Monitor As an ongoing QAA process, facility staff will be re-trained by Staff Development Coordinator or their designees regarding identifying, protecting, investigation and reporting of resident allegations. Additionally, the SSD will interview residents during 1:1 visits and at monthly resident council meetings. The Administrator will monitor allegation investigations and agency reporting. The DoN will report findings to the Quality Assessment and Assurance (QAA) Committee monthly for 3 months. The findings will be provided to the QAA	

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F 226	Continued From page 7 good. She further indicated it was her nursing decision that it was a simple misunderstanding between the resident and the NA and that she did not consider it abuse. She further indicated the resident was normally reliable. During an interview on 3/24/14 at 3:40 pm, NA #3 stated the resident's responsible party came up to her on Saturday March 8, 2014 around dinner time and advised her that the resident stated she had been hit by NA#1 on the day before. NA#3 further stated she told the responsible party that she might want to talk with someone else because she did not know anything about it. She further revealed she did not work on Friday March 7, 2014. NA#3 further indicated she did not tell her nurse that was working at the time because she didn't think the nurse would know anything about the incident. In an interview on 3/25/14 at 8:38 am, Nurse #4 stated he was told by Nurse #3 during the 3pm-11pm to 11pm-7am shift exchange on 3/7/14 that there was an incident involving Resident #2. He further stated Nurse #3 stated the resident had reported that NA#1 had hit her. Nurse #4 stated he was told by the same nurse that the incident had already been reported. He further stated Resident #2 was usually reliable and friendly with staff. A review of the facility documentation revealed the 24 hour report was completed on 3/11/14 at 11:04 am and the 5 day report was completed on 3/18/14 at 5:55 pm. Further review of the facility documentation revealed a revised first sheet of the 5 day report was submitted on 3/19/14 at 2:22 pm. The alleged incident occurred on March 7, 2014. The facility failed to initiate immediate	F 226	committee regarding the April, May and June monitoring. Date of Completion: 04/20/14	

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F 226	Continued From page 8 procedures to protect the resident. The staff accused was suspended on March 10, 2014. During an interview on 3/25/14 at 5:25 pm, the Director of Nursing revealed it was her expectation for the staff to notify her or the administrator of any allegation of abuse immediately.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow the care plan to turn and reposition a resident every two hours for 1 of 2 sampled residents reviewed for total care (Resident #1). Findings included: Resident #1 was admitted into the facility on 2/4/03. Diagnoses included right hemiplegia (paralysis of the arm, leg and trunk - on the same side of the body), cerebrovascular accident (stroke), diabetes, Alzheimer's, joint contracture to upper arm and general weakness. The annual minimum data set completed on 2/15/14 indicated Resident #1 had problems with short and long term memory. Decision with daily decision making was indicated as moderately impaired. There was no rejection of care indicated. Total dependence of one person physical assist was required with bed mobility and	F 282	F282 The facility endeavors to provide the necessary care and services by qualified persons in accordance with each resident□s plan of care. The facility has policies and procedures designed to maintain these goals. Training on how to follow the plan of care is one of many components covered during orientation and through ongoing training. It□s the facility□s intent to ensure all new clinical care staff is instructed regarding care plan policies and procedures. Clinical observations, routine training, audits, medical director and physician reviews, consultant reviews and various quality assurance measures are examples of the many components utilized.	4/20/14

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F 282	Continued From page 9 personal hygiene. Transfer was listed as occurred one once or twice with two person ' s physical assist. The upper extremity (shoulder, elbow, wrist, hand) was impaired on one side. The lower extremity (hip, knee, ankle, foot) was indicated impaired on both sides. The care plan initiated on 2/24/14 as an approach for care, interventions read "turn and reposition every two hours." A review of the physician progress note written on 2/15/14 in part read "profound weakness of the right arm and right leg. Flexion contracture of the right arm as well as both legs." During an observation on 3/25/14 at 10:30 am, Resident #1 when prompted by the treatment nurse to turn and reposition independently was unable to comprehend or perform the task. Care required by the treatment nurse, included her physical turning and repositioning Resident #1 during pressure ulcer care. The resident was unable to offload pressure to his hip and both feet. The resident was observed to be totally dependent on the nursing staff for his care needs. In an interview on 3/25/14 at 1:22 pm, NA #2 stated on March 8, 2014 she was the only NA that was present to care for the residents on A hall. NA #2 indicated that she turned and repositioned Resident #1 twice from 11 pm - 7 am "around 11:30 am and again at 3:00 am." She stated that she informed Nurse #2 that she needed assistance with providing care to all the residents. NA #2 added that Nurse #2 reported back to her that she had contacted the nursing supervisor, who reported that she was not able to get anyone to come in to assist her with the assignment. NA #2 concluded that Nurse #2 only assisted her with care rounds once, which included changing and	F 282	Corrective Action The wound care nurse on 03/24/14 re-reviewed the plan of care for resident #1 and re-assessed resident #1 to ensure care needs were being met. Identification of Others The wound care nurse, DoN and administrative nurses from 03/22/14 through 04/17/14 re-assessed the other residents, on that unit, and their plan of care to ensure care needs were being met. Measures The Director of Nursing (DoN) conducted a root cause review. The policy and procedures for ensuring care plans are followed and staffing assignments met were reviewed. Clinical staff was re-trained by DoN and Staff Development Coordinator on procedures to ensure assignment expectations, assisting each other with care practices when needed and ensuring care plan approaches are followed. Follow-up observations have been conducted by the DoN to monitor re-training. Monitor The DoN, quality assurance nurse or designee will monitor plans of care and staffing assignments at least weekly for 1 month to validate that goals are met. The QAA Committee will evaluate the data for the next 2 quarters to ensure goal(s) achieved.	

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	345353	A. BUILDING _____ B. WING _____	C 03/27/2014

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HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DR PO BOX 35881 FAYETTEVILLE, NC 28301

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F 282	Continued From page 10 repositioning other residents, however, Nurse #2 did not help her with Resident #1 from 11 pm - 7 am. NA #2 added that it was impossible for her to turn and reposition Resident #1 every two hours. She concluded "I did the best I could." Nurse #2 who worked on 3/8/14 was not available to be interviewed. In an interview on 3/25/14 at 4:54 pm, the director of nursing (DON) indicated that she expected Resident #1 to have been turned and reposition every two hours and as needed.	F 282	Date of Completion: 04/20/14	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to turn and reposition a resident while in bed every two hours to relieve pressure, who required total care and was at risk for pressure ulcers for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #1). Findings included: Resident #1 was admitted into the facility on	F 314	F314 The facility endeavors to prevent unavoidable pressure ulcers and provide the necessary care and services to promote healing. The facility has policies and procedures designed to maintain these goals. Wound care training is one of many components covered in ongoing training. It□s the facility□s intent to ensure	4/17/14

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F 314	Continued From page 11 2/4/03. Diagnoses included right hemiplegia (paralysis of the arm, leg and trunk - on the same side of the body), cerebrovascular accident (stroke), diabetes, Alzheimer's, joint contracture to upper arm and general weakness. The annual minimum data set completed on 2/15/14 indicated Resident #1 had problems with short and long term memory. Decision with daily decision making was indicated as moderately impaired. There was no rejection of care indicated. Total dependence of one person physical assist was required with bed mobility and personal hygiene. Transfer was listed as occurred once or twice with two person's physical assist. The upper extremity (shoulder, elbow, wrist, hand) was impaired on one side. The lower extremity (hip, knee, ankle, foot) was indicated impaired on both sides. No weight loss was indicated. A risk for pressure ulcer development was listed. There was no pressure ulcers indicated. Skin ulcer treatment included a pressure reducing device for the bed. The care plan initiated on 2/24/14 as an approach for care, interventions to prevent pressure ulcer development in part read "1) turn and reposition every two hours; 2) heel protectors as needed." A review of the braden scale - a tool for predicting pressure ulcer risk dated 2/10/14 indicated Resident #1 was at moderate risk. A review of the physician progress note written on 2/15/14 in part read "profound weakness of the right arm and right leg. Flexion contracture of the right arm as well as both legs, albumin 3.4" A review of the weekly nursing summary "skin condition" completed on 2/17, 2/24, 3/3/14 revealed no skin concerns. Resident #1's skin	F 314	all new clinical care staff is instructed regarding wound care policies and procedures. Clinical observations, prevention training, wound care audits, medical director and physician reviews, consultant reviews and various quality assurance measures are examples of the many components utilized. Corrective Action Resident #1 was re-assessed by the wound care nurse on 03/10/14 to ensure a complete assessment. Treatment orders were clarified with the MD on 03/10/14. Identification of Others The wound care nurse, DoN, and administrative nurses from 03/22/14 through 4/17/14 re-assessed all other at risk residents for potential wounds. No other residents were affected. Measures The DoN conducted a root cause review. The policy and procedures for skin care and staffing assignments were reviewed. Clinical staff was re-trained by DoN and Staff Development on procedures to ensure assignment expectations, assisting each other with care practices when needed, at risk prevention measures and ensuring skin care approaches are followed. Follow-up observations have been conducted by the DoN to monitor re-training. Monitor	

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F 314	Continued From page 12 was indicated as "good." A review of a written statement completed by the nursing supervisor dated 3/8/14, the nursing supervisor acknowledged that she was informed by Nurse #2 that there were three nursing assistants (NAs) scheduled to work A hall; however, only one NA was available on A hall to care for the residents from 11 pm - 7 am. The supervisor statement concluded that she was unsuccessful with finding coverage and volunteered to come in and work A hall, however, Nurse #2 instructed the supervisor that she would make sure the residents were cared for. A review of the nursing staffing schedule dated 3/8/14 revealed there were four NAs scheduled to work on A hall which included NA #1, #2, #3, and #4. NAs' #3 and #4 names were crossed out on the scheduled. A review of the weekly wound report completed by the treatment nurse on 3/10/14 in part read: 1. "In house acquired: Left 5th metatarsal head (feet) unstageabe 3 centimeter (cm) (length) x 1.5 cm (width), 100% eschar, small amount of serous drainage, autolytic debridement." 2. "In house acquired: Between right 4th/5th toes unstageable 1 cm (length) x 0.4 cm (width), 100 % yellow slough, scant amount of serous drainage, periwound macerated, autolytic debridement." 3. "In house acquired: Right 1st metatarsal head (feet) unstageable 1.5 cm (length) x 1.5 cm (width), 100% yellow slough, scant amount serous drainage, autolytic debridement." 4. "In house acquired: Left trochanter (hip) unstageable 3 cm (length) x 4 cm (width), 30%	F 314	The DoN, quality assurance nurse or designee will monitor plans of care and staffing assignments at least weekly for 1 month to validate that goals are met. The QAA Committee will evaluate the data for the next 2 quarters to ensure goal(s) achieved. Date of Completion: 04/17/14	

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yellow slough; 70% partial thick, small amount serous drainage, periwound fragile, autolytic debridement."

A review of the prealbumin level reported to the facility on 3/12/14 resulted 18.7 (17.0 - 34.0 reference range).

In an interview on 3/24/14 at 2:52 pm, Nurse #1 who worked on 3/10/14 from 7 am - 3 pm stated "NA #2 who worked the weekend of 3/8/14 reported to me that Resident #1 received a skin break down over the weekend due to she did not have help with caring for the resident."

In an interview on 3/25/14 at 10:15 am, the treatment nurse revealed she became aware of Resident #1's pressure ulcers on 3/10/14 by the "day shift nurse." She indicated that upon her initial observation on 3/10/14 there were no initial notes in the medical record in which the pressure ulcers had been assessed or treatment initiated. She added did not know who applied the dressing to the left trochanter (hip) due to there was no staff initial, nor supporting care notes in the medical record. The treatment nurse concluded she assessed the pressures ulcers as occurred in house acquired.

During an observation on 3/25/14 at 10:30 am, the treatment nurse provided pressure ulcer care to the following areas: left 5th metatarsal (feet) unstageable pressure ulcer, between right 4th/5th toes unstageable pressure ulcer, right 1st metatarsal head (feet) unstageable ulcer and the left trochanter unstageable ulcer. Resident #1 when prompted by the treatment nurse to turn and reposition independently was unable to comprehend or perform the task. Care required

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by the treatment nurse, included her physical turning and repositioning Resident #1 during pressure ulcer care. The resident was unable to offload pressure to his hip and both feet. The resident was observed to be totally dependent on the nursing staff for his care needs.

In an interview on 3/25/14 at 10:45 am, the treatment nurse stated that prior to 3/10/14 she had not observed bunny boots and/or feet protectors intact.

In an interview on 3/25/14 at 12:51 pm, Nurse #1 stated that she was informed by NA #2 on 3/10/14, that on the weekend of 3/8/14 she was the only aide that worked the A hall on 3/8/14 and that Resident #1 developed opened areas to his hip and feet.

In an interview on 3/25/14 at 1:22 pm, NA #2 stated on March 8, 2014 she was the only NA that was present to care for the residents on A hall. NA #2 indicated that she turned and repositioned Resident #1 twice from 11 pm - 7 am "around 11:30 am and again at 3:00 am." She stated that she informed Nurse #2 that she needed assistance with providing care to all the residents. NA #2 added that Nurse #2 reported back to her that she had contacted the nursing supervisor, who reported that she was not able to get anyone to come in to assist her with the assignment. NA #2 concluded that Nurse #2 only assisted her with care rounds once, which included changing and repositioning other residents, however, Nurse #2 did not help her with Resident #1 from 11 pm - 7 am. NA #2 added that it was impossible for her to turn and reposition Resident #1 every two hours. She concluded "I did the best I could."

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F 314	Continued From page 15 Nurse #2 who worked on 3/8/14 was not available to be interviewed. In an interview on 3/25/14 at 4:54 pm, the director of nursing (DON) indicated that she expected Resident #1 to have been turned and reposition every two hours and as needed. The DON indicated that per her review of the nursing staffing schedule for 3/8/14 there was no additional nursing coverage provided to assist NA #2 other than Nurse #2. She added that NA #3, #4 did not work; and that NA #1 was originally scheduled to work A hall, however, was pulled to C hall, which left only NA #2 and Nurse #2 on A hall. The DON stated that on 3/8/14 there were 52 residents assigned to NA #2. The DON concluded that Resident #1 had no pressure ulcers leading up to 3/8/14, and that she felt the acquired pressure ulcers could have been prevented.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		4/17/14

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F 356	Continued From page 16 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post the nurse staffing data on 1 of 4 days of the survey. The findings included: An observation during the initial tour of the facility on 3/22/14 at 6:17 am revealed there was no posted nurse staffing data for 3/22/14. Observation was made of the daily nurse staffing sheet dated 3/19/14 posted on the receptionist office window near the entrance door to the facility. The daily nursing staff sheet documents the number of nursing staff (licensed nurses and certified nursing assistants) per shift providing resident care. During an interview on 3/24/14 at 4:00 pm, the scheduler stated she was responsible for posting the daily nurse staffing data. She further indicated she forgot to post the staffing for the past three	F 356	F 356 It is the facility□s normal practice and intent to ensure posting of the nursing staffing data as required. The facility has policies and procedures designed to maintain these goals. Training regarding data posting for each shift is one of many components covered during nursing supervisor training. Audits, staff and supervisor observation, completed data sheet retention, consultant reviews and various quality assurance measures are examples of the many components utilized. The actual hours worked met or exceeded standard of care nursing hours. Corrective Action/Id of Others Based on observations, staff interviews and record reviews, the posting omission was an isolated occurrence. Nursing information was posted on 3/22/14.	

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F 356	Continued From page 17 days. In an interview on 3/25/14 at 5:25 pm, the Director of Nursing stated it was her expectation for the scheduler to post the daily nurse staffing sheet every morning.	F 356	Additional steps were implemented to enhance Quality Assurance efforts. Measures The Director of Nursing (DoN) on 03/24/14 conducted a root cause review. The nurse scheduler was counseled regarding occurrence. The facility policy was reviewed by the administrator and nursing administration. Additional individuals were added to the procedures to assist with the ongoing responsibility for posting and monitoring. The Director of Nursing (DoN) instructed staff, involved in gathering and displaying the nurse staffing information, on the procedural changes. Monitor Completed daily sheets will be given to and reviewed by the DoN or designee prior to filing. The DoN or designee will monitor the displayed posting at least 3 times a week through April. Emphasis will focus on weekend and third shift postings. As part of the Quality Assessment and Assurance (QAA) process, the findings will be provided to the QAA committee regarding the April, May and June compliance monitoring. Date of Completion: 04/17/14	