

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

PRINTED: 10/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2015
NAME OF PROVIDER OR SUPPLIER THE SHANNON GRAY REHABILITATION & RECOVERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2005 SHANNON GRAY COURT JAMESTOWN, NC 27282		
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F 000	INITIAL COMMENTS	F 000			
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interview, the facility failed to fix a broken string to the bathroom call bell for 1 of 40 residents (Resident #228). Findings included:</p> <p>Resident #228 was assessed to be moderately cognitively impaired per Minimum Data Set assessment dated 8/12/15. The assessment described the resident ' s Activities of Daily Living status as needing extensive assistance, and requiring 1 person assist particularly for toilet use and personal hygiene. For bathing, the resident was assessed as needing "physical help in part of bathing activity" ; and for moving on and off toilet, the resident was assessed as "not steady, only able to stabilize with human assistance."</p> <p>The bathroom call bell string was observed to be only 4 inches long upon room observation on 8/25/15 at 3:00 PM. It was noted that the 4 inch</p>	F 246	<p>∩ Call bell string was corrected for resident #228 to a functional length on 8/26/15 during survey. Resident was reviewed by nursing staff and no other needs were identified at this time.</p> <p>∩ A 100% audit was completed by both maintenance staff and administrative staff on 8/26/15 to ensure that all call bells were at functional length within facility. All issues identified were corrected immediately on 8/26/15 by maintenance staff. Facility rounds will identify functional accommodation of needs issues within facility during routine rounds completed by administrative staff and Preventative Maintenance Rounds completed monthly by Maintenance staff. Staff were re-trained about work order system and the expectation to document any issues noted regarding accommodation of needs</p>	9/18/15	

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

TITLE

(X6) DATE

Electronically Signed

09/17/2015

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 246	<p>Continued From page 1</p> <p>string was broken and the remainder of the string was hanging in a loop off of a nearby bathroom towel hook. This observation was made on 8/25/15 at 3:00 PM, 8/26/15 at 9:00 AM, and at 8/26/15 at 3:00 PM.</p> <p>The resident indicated on 8/26/15 at 2:00 PM that the string has been broken since he arrived to the facility. He further stated that "I've told everyone about it. They say that they will get to it. My wife has even reported it. It irritates me; I've given up on it ever getting fixed." He denied having any negative outcomes as a result of the shortened string but he stated "I am a private person and like to take care of myself. It concerns me that I may be in the bathroom and may need help but cannot get it. I have tried tying it back together two or three times but my Boy Scout knot didn't hold."</p> <p>The Maintenance Director was interviewed on 08/26/2015 at 3:09 PM. He reviewed his work order book and confirmed that there were no work orders for bathroom call bell issues. He further stated that "We don't do routine maintenance rounds. We rely on staff to tell us about maintenance issues. Staff communicate maintenance issues with us by filing out a report in our book or by telling us verbally during our meetings in the morning. I would need to fix the string so that it sits a few inches off of the ground so that the resident can access it. A short string would be an accessibility issue. All of our call bell strings are the same length; they should sit just a few inches off of the floor."</p> <p>A nursing assistant was interviewed at 5:00 PM on 8/26/15. She stated "I help (Resident # 228) on and off the toilet, but he does things like</p>	F 246	<p>to Maintenance Staff using the work order system. Work order system reminders will be provided at all up coming all staff inservices as deemed necessary. Administrative staff will also complete work orders as they identify issues on their routine rounds. Staff are informed of facility work order system in new employee orientation.</p> <p>¿ A QI audit was initiated for all resident rooms within facility for a minimum of monthly check for functional/accommodation items such as call bell cord length. A QI tool ¿ Preventative Maintenance (PM) Room Rounds¿ was implemented on 9/15/15 as was a schedule to ensure that all resident rooms within facility are audited a minimum of monthly by Maintenance Staff. In addition, administrative staff is assigned facility rounds. Administrative staff will monitor their assigned area using a "Room Rounds" QI Tool for any accommodation of needs issues 3-5 times per week. All accommodation of needs issues that are identified with completion of audits will be corrected at the time of audit with work orders completed for any non-emergent issue. Administrator or Designee will audit monthly to ensure all rooms audits have been completed and will check a minimum of 10 random rooms weekly X4 and monthly on-going to ensure that above mentioned QIs are effective in identifying accommodation of needs issues. Any issues will be addressed with the Maintenance Director and Reported to QI for recommendation as appropriate.</p>		

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F 246	Continued From page 2 brushes his teeth and gets dressed by himself. I noticed that the call bell string was broken last Thursday and so I wrote a work order and put it in the work order notebook." The Maintenance Director was re-interviewed at 5:08 PM on 8/26/15. He re-confirmed that he had not received a work order for any call bell string issue. He further stated that "routine monthly rounds are not possible for the 2 individuals who are employed by the facility to work on maintenance issues. We have 96 rooms, and so the 2 of us cannot get to all of them every month. The issue should have been caught and reported by the nursing assistants earlier." The Administrator was interviewed on 8/27/15 at 7:30 AM. She indicated that she was under the expectation that routine monthly rounds were actually being conducted by maintenance and that the room should have been checked for "move-in perfect readiness" for the incoming resident (Resident #228). She indicated that if all of this rounding and checking was actually being conducted than the issue would have been caught and fixed. The Director of Nursing was interviewed on 08/26/2015 4:10 PM. She stated "My expectation is that the staff communicate needs with maintenance and if regular rounds by maintenance are not being done then I would notify my administrator. If a resident told a staff member about any maintenance issue I would expect that staff member to inform maintenance to get it fixed."	F 246	Completed QI audits will be reviewed by the administrator a minimum of monthly with a quarterly report of issues being reported to Executive QI committee. Reporting will continue a minimum of 3 quarters at which time the Executive QI committee will reassess for continued need. Changes in auditing frequency or content will be changed by the Executive QI Committee if deemed appropriate and reflected accordingly.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		9/18/15	

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F 278	<p>Continued From page 3</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to identify on admission the placement of an indwelling catheter on 1 of 14 sampled residents (Resident #238) surveyed for the use of an indwelling catheter and the facility failed to accurately assess 1 of 1 residents (Resident #129) Preadmission Screening and</p>	F 278	<p>Resident #238 received order for indwelling catheter on 8/25/15. Physician reviewed on 8/28/15 and agreed with continued indwelling catheter use. MDS was completed for admission assessment on 8/27/15 which assessed use of indwelling catheter. Resident #129</p>		

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F 278	<p>Continued From page 4</p> <p>Resident Review on a comprehensive assessment during readmission to the facility. Findings include:</p> <p>1) Resident #238 was admitted to the facility on 8/20/2015 at 2:40 PM. He was transported to the facility via Emergency Medical Services from the local international airport where he flew in from another state for continuation of care. A Resident Assessment-Data Collection Form was signed and dated as completed by Nurse #4 on 8/20/2015 the date of Resident #238 's admission. The form for Resident #238 included a diagnoses of Intracranial Hemorrhage. The assessment and data collection on the front page of the form was completed. The assessment and data collection on the back was left blank, sections 5 through 13, including an assessment (type and size) for an indwelling catheter in section 12.</p> <p>An admission nurse note dated 8/20/2015 AT 2:40 PM signed by Nurse #4 revealed Resident #238 was alert, oriented to self, disoriented to time and place, and unable to recall recent events. Nurse #4 ' s admission nurse note included condom catheter intact, patent, and draining quantity sufficient amount of amber urine.</p> <p>A record review of Resident #238 ' s admission treatment record or flow sheet completed by Nurse #4, dated 8/20/2015 did not include care for an indwelling or condom catheter.</p> <p>A record review of Resident #238 ' s interim care plan was completed by Nurse #5, dated 8/20/2015 and marked condom catheter for bladder status.</p> <p>A record review of a fax dated 8/24/2015 included a hospital discharge summary (history and physical) for Resident #238. Included was the placement of an indwelling catheter.</p>	F 278	<p>received a modification to prior assessment on 8/26/15 addressing the change in status to Level 1 PASSAR. Modification completed by RN, MDS Coordinator.</p> <p>¿ 100% audit was completed for all residents who have indwelling catheters to ensure that accurate assessment is in place. Audit was completed on 8/26/15. All residents were audited for appropriate PASSAR assessment. Corrections were made at the time of audit. Nursing staff inservice was completed on 8/25 ¿ 8/27/15 regarding proper admission assessment process including through assessment of indwelling catheters, full head- to- toe assessments and appropriate follow-up on any issues identified. Admitting nurse and Unit manager are responsible to ensure that all new admission residents have through admission assessment with all issues identified at time of admission. Inservicing was conducted with MDS Nurses and Social Workers to discuss PASSAR assessment and screening. Social services and admissions coordinator are involved in pre-admission screening and ensuring that PASSAR is obtained prior to admission. MDS Coordinator has been made responsible for accuracy of ¿Section A¿ of MDS to match PASSAR screening information. MDS nurse will ensure that all residents MDS assessments have appropriate PASSAR coding per RAI manual guidelines.</p> <p>¿ The New Admission Audit was revised to include indwelling catheter specifically.</p>		

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F 278	<p>Continued From page 5</p> <p>On 8/25/2015 at 4:00 PM an interview with Nurse #6 revealed Resident #238 had an indwelling catheter. She reported she took care of Resident #238 all weekend and he had an indwelling catheter. Nurse #6 reported the process for admission documentation was to assess the resident on admission and draw the indwelling catheter in the picture [to indicate body markings on the skin assessment section of the Resident Assessment-Data Collection Form], write an order for the catheter for the physician to sign, add the catheter to care plan and the treatment record.</p> <p>On 8/25/2015 at 4:00 PM Nurse #8 who was a unit coordinator was in disagreement with Nurse #6 about the status of Resident #238 indwelling catheter. She reported at this time he did not have an indwelling catheter. At 4:05 PM Nurse #7 verified the presence of the indwelling catheter for Resident #238.</p> <p>On 08/26/2015 at 8:53 AM an interview with Nurse #4 who was the admission nurse for Resident #238 revealed the admission process was the following: Nurse #7 verified Resident #238 ' s medications and treatments from the medical record and transcribed Resident #238 ' s orders on to the physician order sheet. Nurse #4 reported she completed the head to toe assessment [Resident Assessment-Data Collection Form]. Nurse #4 reported she initiated Resident #238 ' s assessment on 08/20/15 and asked the nursing assistant (NA) to disrobe Resident #238 and put him in one of the facility gowns so she could look at his perineum and buttocks. Nurse #4 did not know why the head to toe assessment form was not completed. Nurse #4 reported she must have " gotten called away " or her " flag " was removed causing her to not recall the incomplete assessment. She stated she</p>	F 278	<p>A QI tracking log was implemented to audit completion of new admission audits as well as the nurses who completed new admission and audits of said admissions. This QI tracking log will be maintained by unit managers and reviewed a minimum of weekly by the DON. DON will report any concerns related to new admission audits to Administrator as issues or trends are noted. A tracking tool has been implemented for PASSAR tracking and coding. The MDS coordinator will ensure that this tracking log is maintained and that the coding for all PASSAR levels are correct on MDS per RAI guidelines. The administrator will randomly audit assessments completed weekly X4 and monthly thereafter to ensure that appropriate PASSAR assessment and coding is occurring.</p> <p>QI audits for new admissions and PASSAR assessments will be reviewed by the administrator monthly. Assessment Audits will be reported to Executive QI Committee quarterly with any changes in plan or follow-up directed by Executive QI Committee. Reporting will continue a minimum of 3 quarters at which time the Executive QI committee will reassess for continued need. Changes in auditing frequency or content will be changed by the Executive QI Committee if deemed appropriate and reflected accordingly.</p>		

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F 278	Continued From page 6 " got pulled in 1000 different directions. " Nurse #4 reported she did not get the boxes filled in [assessment data] on the head to toe assessment but she completed the assessment and could refer to her admission nurse note. Nurse #4 reviewed Resident #238 ' s admission nurse note. Nurse #4 stated " it looks like I miss wrote " referring to the documentation that Resident #238 had a condom catheter intact, patent, and draining quantity sufficient amount of amber urine. Nurse #4 reported she remembered Resident #238 had on two pairs of pants and she saw his leg bag [collection container for the catheter]. Nurse #4 stated again " I miss wrote " and she did not know why she documented that Resident #238 had a condom catheter. Nurse #4 stated " I did not have the opportunity to assess his (Resident #238) perineum. " Nurse #4 added she was pulled in a lot of different directions, the second shift nurse [7 PM] did not show for work, and the facility had some staffing issues. Nurse #4 stated " I felt like I was spread thin. I do not know why it [perineum or catheter assessment] was missed. It [responsibilities on assignment] is too much work for one nurse to handle. " Nurse #4 reported there was a 24 hour assessment period, a continuation of nursing care, to complete the admission forms. The nurse who admitted the resident was responsible for the head to toe assessment, pain assessment, and admission note. She reported Resident #238 was admitted at 2:40 PM. Nurse #5 was the relieving nurse and completed the remainder of the admission packet. Nurse #4 revealed a physician order was needed for an indwelling catheter [in place] and a condom catheter [documented] but she did not write the order. Nurse #4 revealed she initiated the treatment record but her head to toe assessment stopped at the peg tube (feeding	F 278			

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F 278	Continued From page 7 tube inserted in the abdomen) that was transcribed on the treatment record. " I did not get the assessment completed. " On 8/26/2015 at 8:48 AM an interview with NA#7 revealed her knowledge that Resident #238 was admitted with an indwelling catheter and a leg bag. A record review on 8/27/2015 of Resident Status Sheet [a tool used by the nursing assistant staff] 7 days post admission was blank. On 8/27/2015 10:00 AM an interview with NA #8 revealed the nursing staff completed the Resident Status Sheet and placed it in the NA log book as a care reference. On 8/27/2015 at 10:15 AM an interview with Nurse #5 revealed Resident #238 was admitted on 1st shift on 08/20/15. Nurse #5 was on call and arrived at 8:50 PM to receive report from Nurse #4. Nurse #5 recalled that Nurse #4 did the admission note and skin assessment. Nurse #5 report she did a few of the admission assessments. She reported she reviewed the medical record from the discharge hospital but she could not find the physician history and physical. Nurse #5 reported she read the paperwork/history that was provided. She reported, Nurse #4 reported Resident #238 had a condom catheter. Nurse #5 routinely read the physician history and physical and did an assessment on the resident but there was no history and physical in the paperwork which would have included the type of catheter. Resident #238 was disoriented and would not let her do a visual assessment for a catheter. Nurse #5 reported she was looking for the history and physical for justification so she could discontinue the catheter if needed. Nurse #5 reported she could not find the answer and reported in the morning that Resident #238 had a condom catheter.	F 278			

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F 278	<p>Continued From page 8</p> <p>On 8/27/2015 at 11:50 PM an interview with the Director of Nursing revealed her expectation was for the admission nurse to do a full head to toe assessment on admission and complete the documentation for the head to toe assessment. Her expectation was for all the nursing staff to accurately and fully complete the admission packet paperwork.</p> <p>Resident #129 was admitted on 8/10/15 with multiple diagnoses including depression.</p> <p>Record review of resident #129 ' s level of care screening tool indicated pre admission screening and resident review (PASRR) number ending in " A " .</p> <p>Record review of North Carolina Medicaid Uniform Screening Tool (NCMUST) revealed resident #129 ' s PASRR history indicated resident #129 ' s PASRR number ending in " A " started from 8/5/15.</p> <p>Record review of resident #129 ' s minimum data set (MDS) assessment, dated 8/17/15, revealed that PASRR section was coded as Level II.</p> <p>On 8/26/15 at 1:30 PM, during an interview, the social worker (SW) stated that she did not complete or review the PASRR section of 8/17/15 MDS assessment because the information, including PASRR level, was pre populated on the computer system from the previous resident ' s admission.</p> <p>On 8/26/15 at 1:40 PM, during an interview, the</p>	F 278			

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F 278	Continued From page 9 administrator stated that her expectation was that the staff should accurately complete the PASRR section of MDS. When the computer system prepopulated any of previous admission information, the MDS nurse should review and change it manually when applicable. On 8/26/15 at 1:50 PM, during an interview, the Director of Admissions stated that resident #129 was assessed as PASRR level II in 2014 and became PASRR level I during the last hospitalization prior to readmission in the facility. On 8/26/15 at 2:50 PM, during an interview, the MDS nurse stated that the 8/17/15 MDS assessment indicated wrong information about resident #129 's PASRR level, it should be coded as level I instead of level II. The Social Worker was responsible for completing the PASRR section of that assessment.	F 278			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		9/18/15	

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F 431	<p>Continued From page 10</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to maintain medication storage refrigerator temperatures according to manufacturer recommendations for safe drug storage for 1 of 4 nursing station refrigerators (Refrigerator #1). Findings included: Medication storage review was conducted on 8/27/15 at 11:15 AM. The log of the August 2015 refrigerator temperatures for Refrigerator #1 showed 4 consecutive days and 2 additional days of temperatures above the manufacturer recommended storage temperature of 36-46 degrees Fahrenheit (August 3-6, 10th, and 13th at 48 degrees Fahrenheit). The temperature log was taped to the outside door of the refrigerator. It was noted that a note at the top of the log stated "Temperature should range from 36 to 46. If not in range identify corrective action taken</p>	F 431	<p>¿ Refrigerator was adjusted at the time of the survey and temperature was within range within 2 hours of adjustment.</p> <p>¿ All medication refrigerators were audited at time of survey and issues of temperature were addressed immediately by nursing staff. Temperature log remains in place with directions to the nursing staff when temperatures are out of range.</p> <p>¿ All licensed nurses were re-trained on 8/27/15 (either in person or via telephone) regarding their responsibility to maintain appropriate temperatures in the medication storage refrigerator and take immediate action if the medication refrigerators are not within acceptable range. This will also be addressed with all new nurses when in orientation.</p>		

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OMB NO. 0938-0391

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F 431	<p>Continued From page 11</p> <p>under comments (temperature turned down/up, maintenance called, etc ...After corrective action taken, recheck temperature in one hour and record in the recheck column. If temperature is still out of range after one hour contact your immediate supervisor for further instructions - i.e. for possible relocating of medications".</p> <p>Medications observed in the refrigerator included 2 Novolog insulin vials, acetaminophen suppositories, and Bisacodyl suppositories, all of which are to be stored at a temperature range of 36-46 degrees Fahrenheit per manufacturer recommendations.</p> <p>The nurses (Nurse #1, Nurse #2, Nurse #3) who had signed off on the temperature on the above listed dates were not available by phone for comment.</p> <p>The Maintenance Director was interviewed on 8/27/15 at 11:18 AM. He confirmed that he had not received any work orders about medication refrigerator temperature issues. He stated "I would expect staff who was monitoring the temperatures to let us know if there was a problem. I calibrated the refrigerator temperature and it appears that the thermometer reads accurately."</p> <p>The Director of Nursing was interviewed on 8/27/15 at 11:10 AM. She indicated that she was not informed of any medication refrigerator issues by the nursing or maintenance staff. After reviewing the logs for August 2015, she indicated that nursing staff were monitoring the temperatures as required on a daily basis but apparently not understanding the need for monitoring and not recognizing the issue of out of range temperatures. She described her expectations include nursing staff readjust the refrigerator temperature, recheck in an hour to ensure appropriate temperature, alert</p>	F 431	<p>¿ Refrigerator temp logs will be monitored weekly by QI nurse or designee. A QI audit tool ¿Medication Refrigerator QI¿ will be utilized. Any issues identified will be corrected immediately with maintenance director involvement as needed. Any trends related to lacking documentation or accountability will be reported to DON for follow up with specific employees including retraining or disciplinary action as appropriate. Trends, if identified, will be reported to Executive Committee quarterly for a minimum of 3 quarters at which time the Executive QI committee will reassess for continued need. Changes in auditing frequency or content will be changed by the Executive QI Committee if deemed appropriate and reflected accordingly.</p>		

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F 431	Continued From page 12 maintenance and administration if the problem continues, and contact pharmacy to have the affected medications replenished. She indicated that none of this was happening; she also indicated that the pharmacy technician was at the facility earlier this week to check temperatures and had not informed her of any issues.	F 431			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		9/18/15	

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F 520	Continued From page 13 Based on staff interview and record review the facility failed to implement the appropriate plan of action to correct 1 of 1 Quality Assessment and Assurance committee identified quality deficiency for the admission process to ensure all assessments were accurate and completed. Findings included: On 8/27/2015 at 12:30 PM an interview with the Director of Nursing (DON) revealed the facility identified a quality deficiency in the admission process and an admission audit tool was put in place on 6/1/2015 to ensure staff compliance and assessments were not being missed. The unit coordinators were to utilize the tool 24 hours post resident admission to check for missed assessments. [The tool included check offs for review history, complete assessments, order verification, and treatments]. The DON reported the only negative outcome to date was the audit tool was not always being completed in the 24 hours from admission to the facility until the current discovery on Resident #238. On 8/25/2015 at 3:30 PM a record review was completed on Resident #238 medical record. A Resident Assessment-Data Collection Form was signed and dated as completed by Nurse #4 on 8/20/2015 the date of Resident #238 's admission. The assessment and data collection on the front page of the form was completed with the exception of the respiratory functional status in section 3 i.e. use of Oxygen. The assessment and data collection on the back was left blank, sections 5 through 13: visual difficulty, communication, oral assessment, eating/nutrition i.e. feeding tube placement, personal hygiene, sleeping patterns, psych/social/mood, bowel and bladder i.e. catheter type and size, and orientation to the facility. The treatment record or flow sheet was not completed with the	F 520	<p>¿ The New Admission QI audit was revised at the time of survey to include detailed information regarding indwelling catheters. Responsibility was given to Unit Managers to consistently complete the new admission audit, with accountability for the audit being placed on a different unit manager as a unit manager often assists with the admission process itself. Retraining was conducted with nurses (Nurse #4 and #7) who conducted the admission assessment and audit for resident #238 during the survey, retraining included verification of assessment accuracy by nurse doing QI audit of admission (Completed on 8/26/15 by DON).</p> <p>¿ All Licensed nurses were retrained regarding admission process and follow up new admission QI process. Emphasis was placed on thorough documentation and accurate assessments. The revised New Admission QI tool will be utilized with all new admissions. The New Admission QI tool and process will be updated as directed by the DON as any further issues are identified by QI committee.</p> <p>¿ The DON or Designee will audit all New Admission QI audits to verify that they are complete and accurate. Any issues identified of inaccurate assessment or poor follow-up will be addressed by DON with the nurse or nurses responsible including retraining and/or disciplinary action as appropriate.</p> <p>¿ The New Admission QI Audits including the DON review of these completed reports will be reviewed by the administrator a minimum of monthly.</p>		

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F 520	Continued From page 14 appropriate treatments i.e. catheter care for Resident #238 based on the admission nurse note. The physician orders were reviewed and there was no order transcribed for the (indwelling documented as condom) catheter. A Resident Status Sheet [a tool used by the nursing assistant staff] was blank for all areas of care. On 08/26/2015 at 8:53 AM an interview with Nurse #4 who was the admission nurse for Resident #238 revealed the admission process was the following: Nurse #7 verified Resident #238 ' s medications and treatments from the medical record and transcribed Resident #238 ' s orders on to the physician order sheet. Nurse #4 reported she completed the head to toe assessment [Resident Assessment-Data Collection Form]. Nurse #4 reported there was a 24 hour assessment period, a continuation of nursing care, to complete the admission forms. The nurse who admitted the resident was responsible for the head to toe assessment, pain assessment, and admission note. She reported Resident #238 was admitted at 2:40 PM. Nurse #5 was the relieving nurse and completed the remainder of the admission packet. Nurse #4 revealed a physician order was needed for an indwelling catheter [in place] and a condom catheter [documented] but she did not write the order. Nurse #4 revealed she initiated the treatment record but her head to toe assessment stopped at the peg tube (feeding tube inserted in the abdomen) that was transcribed on the treatment record. " I did not get the assessment completed. " On 8/27/2015 10:00 AM an interview with NA #8 revealed the nursing staff completed the Resident Status Sheet and placed it in the NA log book as a care reference. NA #8 reported she did not know where Resident #238 ' s Resident Status	F 520	Trends and summary will be reported to the Executive Committee quarterly. Reporting will continue a minimum of 3 quarters at which time the Executive QI committee will reassess for continued need. Changes in auditing frequency or content will be changed by the Executive QI Committee if deemed appropriate and reflected accordingly.		

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F 520	<p>Continued From page 15</p> <p>Sheet was because it was the responsibility of the nurse.</p> <p>On 8/27/2015 at 10:15 AM an interview with Nurse #5 revealed Resident #238 was admitted on 1st shift. Nurse #5 was on call and arrived at 8:50 PM to receive report from Nurse #4. Nurse #5 recalled that Nurse #4 did the admission note and skin assessment. Nurse #5 report she did a few of the admission assessments. She reported she reviewed the medical record from the discharge hospital but she could not find the physician history and physical. Nurse #5 reported she read the paperwork/history that was provided. She reported, Nurse #4 reported Resident #238 had a condom catheter. Nurse #5 routinely read the physician history and physical and did an assessment on the resident but there was no history and physical in the paperwork which would have included the type of catheter.</p> <p>A record review of a fax received on 8/24/2015 at 9:43 AM included a hospital discharge summary for Resident #238. Included in the discharge summary for Resident #238 was the use of an indwelling catheter, a peg tube placement, and the use of BiPAP (form of oxygen therapy).</p> <p>A record review of an admission audit tool for Resident #238 was signed and completed on 8/21/2015 by Nurse #7 the unit coordinator. The areas included (in part):</p> <ul style="list-style-type: none"> Read the History and Physical Read Discharge Summary Read the Admission Nurse Note Orders Verified Check the TAR (treatment record) Interim Care Plan <p>Areas not included in the audit tool were the Assessment- Data Collection Form, Resident Care Guide, or an area to verify the use of invasive medical devices e.g. gastrostomy tubes</p>	F 520			

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F 520	Continued From page 16 and catheters, and that orders and treatments were carried out for the invasive medical devices. On 8/26/2015 at 4:30 PM an interview with Nurse #7 the unit coordinator revealed she verified Resident #238 ' s medications and treatments from the medical record and transcribed Resident #238 ' s orders on to the physician order sheet indicated by her signature. Nurse #7 reported the admission nurse had to complete the pain assessment, skin assessment, nursing note, and skin test (diagnostic for infection) before the shift change but the admission nurse can report off what additional assessments need to be completed to the relieving nurse. Nurse #7 reported the admission packet process can be completed in the first 24 hours of a resident admission to the facility. The admission audit tool needed to be completed by a unit coordinator at 24 hours post admission. Nurse #7 reported she completed her own audit on Resident #238 because of staffing availability and the 24 hour deadline. When asked if she read the history and physical, discharge summary or the admission nurse note for accuracy as titled on the audit tool Nurse #7 reported the audit tool was to check off the paper work was completed. She reported she did not read the content to verify accuracy she expected the nurse to do an accurate assessment. On 8/27/2015 at 11:50 PM an interview with the Director of Nursing revealed her expectation was for the admission nurse to do a full head to toe assessment on admission and complete the documentation for the head to toe assessment. Her expectation was for all the nursing staff to accurately and fully complete the admission packet paperwork.	F 520			