STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING ______ B. WING ______	C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	**306 DEER PARK ROAD NEBO, NC 28761**

(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	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		12/16/16

(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities 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.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/12/2016

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 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to investigate an injury of unknown origin and file a 24 hour and 5 working day report to the North Carolina Health Care Personnel Investigations (NCHCPI) for 1 of 1 resident reviewed for an injury of unknown origin (Resident #7). The findings included: Resident #7 was admitted to the facility on 09/03/14 with diagnoses of dementia without behavioral disturbance, thrombocytopenia (deficiency of platelets in the blood), and cognitive	F 225	1. The 1 day and 5 day investigative reports were submitted on 11/22/16 & 11/28/16 respectfully by the Administrator to the North Carolina Health Care Personnel Investigations (NCHCPI) for resident #7. 2. All residents have the potential to be affected. An audit of incident for the last 90 days was completed on 11/30/16 by the Director of Clinical Operations to ensure known causes were present for any injury. Identified injuries with no known cause were reported to NCHPI as	

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SUNRISE REHABILITATION & CARE	**306 DEER PARK ROAD** **NEBO, NC 28761**

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F 225	Continued From page 2 communication deficit. The annual Minimum Data Set (MDS) dated 08/22/16 indicated Resident #7 had moderately impaired cognition but was understood and could usually understand. Review of the facility incident reports for 09/2016 through 11/2016 revealed an incident report of an incident for Resident #7 on 09/13/16. The report indicated Resident #7 had a large hematoma to the left mid/inner thigh and a small bruise to the left side of the nose. The incident report was signed by Nurse #1, the Director of Nursing (DON), and the Administrator. Review of the nurse's notes from 08/22/16 through 11/21/16 revealed Nurse #1 had made the following entry which read in part: 09/13/16 at 1:30 PM-Nursing assistant (NA) reported Resident #7 had a bruise to the left thigh and to the nose. The resident was examined and noted to have an orange sized hematoma to the left inner mid-thigh area, slightly bluish in color and noted to be approximately 2 centimeters (cm) by 1 cm and the left side of the nose the area was blue in color. The Physician Assistant (PA) was notified and no new orders were obtained and the resident's representative was also notified. Further review of the medical record revealed a progress note dated 09/13/16 by the PA which read in part Resident #7 was evaluated in regards to a bruising with hematoma to the left medial thigh area. The PA indicated in the progress note that Resident #7 was cooperative during the exam and seemed concerned that the bruise was there but was unaware of how it had happened. Nurse #1 was unable to be interviewed in regards to being out of work on medical leave.	F 225	required by the administrator. 3. The administrator received education regarding the reporting the abuse program, reporting requirements and completing investigation for allegations of abuse, neglect, exploitation or mistreatment, to include injuries of unknown origin by the Director of Operational Support on 11/28/16. The interim administrator received education regarding the reporting the abuse program, reporting requirements and completing investigation for allegations of abuse, neglect, exploitation or mistreatment, to include injuries of unknown origin by the Director of Clinical Operations on 11/30/16. Facility staff education regarding reporting of abuse, neglect, exploitation, mistreatment to include bruises was initiated on 11/25/16. Employees not working during the education time frame (i.e. FMLA, PRN); will receive this education prior to their next scheduled shift by the interim administrator or designee. Newly hired employees will receive abuse training as part of the new hire orientation. 4. Incident reports will be reviewed to ensure causes of injuries, to include, but not limited to bruises, skin tears or fractures are known or that an investigation has been initiated and the incident reported to NCHCPI as appropriate; will be completed 5 X weekly	

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F 225	Continued From page 3 An interview was conducted with Nurse #2 on 11/22/16 at 3:05 PM. Nurse #2 confirmed she was the 2nd shift supervisor on 09/13/16 and she was made aware of Resident #7's hematoma by Nurse #1. Nurse #2 stated she was unaware of how Resident #7 obtained the hematoma but had speculated that it was caused by the straps on the mechanical lift sling which crisscrossed between the resident's legs during transfer. An interview was conducted with the interim DON on 11/22/16 at 3:20 PM. The DON stated she was not employed by the facility at the time of the incident and she was unaware of the incident until 11/22/16. The DON further stated she would have expected a 24 hour and a 5 working day report to have been completed at the time of the incident due to not knowing for 100 % certainty of what had happened. The DON indicated there were problems with incident reporting and this particular incident was not identified until 11/22/16. The DON further indicated there was no 24 hour or 5 working day report completed in regards to the injury of unknown origin. An interview was conducted with Nurse #3 on 11/22/16 at 4:22 PM. Nurse #3 confirmed she was the interim DON in 09/2016 during the time of the injury of Resident #7. Nurse #3 stated she was made aware of the hematoma to Resident #7's left inner thigh and on the nose on 09/13/16. Nurse #3 indicated the hematoma had defined margins, was purplish/blue in color, and was egg shaped. Nurse #3 further indicated at the time of the injury no one in the facility re-enacted the incident to determine exactly what had happened and therefore there should have been a 24 hour and a 5 day working report completed for an	F 225	by the Administrator/ DON/Designee. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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F 225	Continued From page 4 injury of unknown origin. An interview was conducted on 11/22/16 at 6:11 PM with the Administrator. The Administrator confirmed her signature on the incident report dated 09/13/16. The Administrator stated she could not remember the incident or the specifics of the incident. She further stated she had read the incident report, signed it, and stated "there are some important missing pieces." The Administrator indicated there was nothing done to ensure the safety of the other residents in the facility and that a 24 hour and a 5 day working report should have been completed and an investigation conducted.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum	F 226		12/16/16

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educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to follow their abuse policy and procedure to investigate an injury of unknown origin and file a 24 hour and 5 working day report to the North Carolina Health Care Personnel Investigations (NCHCPI) for a resident with a large hematoma for 1 of 1 residents sampled for abuse (Resident #7).

The findings included:

A review of the facility's abuse policy dated 05/01/14 indicated under a section titled Process: Under section H titled Identification read in part that identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse, neglect and/or mistreatment and investigate. The policy indicated in part the Administrator and Director of Nursing would provide notice to all appropriate state and regulatory agencies.

Resident #7 was admitted to the facility on 09/03/14 with diagnoses of dementia without behavioral disturbance, thrombocytopenia

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1. The 1 day and 5 day investigative reports were submitted on 11/22/16 & 11/28/16 respectfully by the Administrator to the North Carolina Health Care Personnel Investigations (NCHCPI) for resident #7.

2. All residents have the potential to be affected. An audit of incident for the last 90 days was completed on 11/30/16 by the Director of Clinical Operations to ensure known causes were present for any injury. Identified injuries with no known cause were reported to NCHPI as required by the administrator.

3. The administrator received education regarding the reporting the abuse program, reporting requirements and completing investigation for allegations of abuse, neglect, exploitation or mistreatment, to include injuries of unknown origin by the Director of Operational Support on 11/28/16.

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(deficiency of platelets in the blood), and cognitive communication deficit. The annual Minimum Data Set (MDS) dated 08/22/16 indicated Resident #7 had moderately impaired cognition but was understood and could usually understand.

A review of the facility abuse investigations revealed there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Investigations for Resident #7.

Review of the nurse's notes from 08/22/16 through 11/21/16 revealed Nurse #1 had made the following entry which read in part: 09/13/16 at 1:30 PM-Nursing assistant (NA) reported Resident #7 had a bruise to the left thigh and to the nose. The resident was examined and noted to have an orange sized hematoma to the left inner mid-thigh area, slightly bluish in color and noted to be approximately 2 centimeters (cm) by 1 cm and the left side of the nose the area was blue in color. The Physician Assistant (PA) was notified and no new orders were obtained and the resident's representative was also notified.

Further review of the medical record revealed a progress note dated 09/13/16 by the PA which read in part Resident #7 was evaluated in regards to a bruising with hematoma to the left medial thigh area. The PA indicated in the progress note that Resident #7 was cooperative during the exam and seemed concerned that the bruise was there but was unaware of how it had happened.

An interview was conducted with Nurse #2 on 11/22/16 at 3:05 PM. Nurse #2 confirmed she was the 2nd shift supervisor on 09/13/16 and she was made aware of Resident #7's hematoma by Nurse #1. Nurse #2 stated she was unaware of

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The interim administrator received education regarding the reporting the abuse program, reporting requirements and completing investigation for allegations of abuse, neglect, exploitation or mistreatment, to include injuries of unknown origin by the Director of Clinical Operations on 11/30/16.

Facility staff education regarding reporting of abuse, neglect, exploitation, mistreatment to include bruises was initiated on 11/25/16. Employees not working during the education time frame (i.e. FMLA, PRN); will receive this education prior to their next scheduled shift by the interim administrator or designee. Newly hired employees will receive abuse training as part of the new hire orientation.

4. Incident reports will be reviewed to ensure causes of injuries, to include, but not limited to bruises, skin tears or fractures are known or that an investigation has been initiated and the incident reported to NCHCPI as appropriate; will be completed 5 X weekly by the Administrator/ DON/Designee. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.

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how Resident #7 obtained the hematoma but had speculated that it was caused by the straps on the mechanical lift sling which crisscrossed between the resident's legs during transfer.

An interview was conducted with the interim DON on 11/22/16 at 3:20 PM. The DON stated she was not employed by the facility at the time of the incident and she was unaware of the incident until 11/22/16. The DON further stated she would have expected a 24 hour and a 5 working day report to have been completed at the time of the incident due to not knowing for 100 % certainty of what had happened. The DON indicated there were problems with incident reporting and this particular incident was not identified until 11/22/16. The DON further indicated there was no 24 hour or 5 working day report completed in regards to the injury of unknown origin.

An interview was conducted with Nurse #3 on 11/22/16 at 4:22 PM. Nurse #3 confirmed she was the interim DON in 09/2016 during the time of the injury of Resident #7. Nurse #3 stated she was made aware of the hematoma to Resident #7's left inner thigh and on the nose on 09/13/16. Nurse #3 indicated the hematoma had defined margins, was purplish/blue in color, and was egg shaped. Nurse #3 further indicated at the time of the injury no one in the facility re-enacted the incident to determine exactly what had happened and therefore there should have been a 24 hour and a 5 day working report completed for an injury of unknown origin.

An interview was conducted on 11/22/16 at 6:11 PM with the Administrator. The Administrator confirmed her signature on the incident report dated 09/13/16. The Administrator stated she

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F 226	Continued From page 8 could not remember the incident or the specifics of the incident. She further stated she had read the incident report, signed it, and stated "there are some important missing pieces." The Administrator indicated there was nothing done to ensure the safety of the other residents in the facility and that a 24 hour and a 5 day working report should have been completed and an investigation conducted.	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		12/16/16

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F 309	Continued From page 9 Based on record review and staff interviews the facility failed to assess a hematoma for a resident with a platelet disorder for 1 of 4 sampled residents reviewed for maintaining well-being (Resident #7). The findings included: Resident #7 was admitted to the facility on 09/03/14 with diagnoses of dementia without behavioral disturbance, thrombocytopenia (deficiency of platelets in the blood/platelet disorder), and cognitive communication deficit. An annual Minimum Data Set (MDS) dated 08/22/16 indicated Resident #7 had moderately impaired cognition but was understood and could usually understand. The MDS revealed Resident #7 required extensive assistance with transfers, dressing, eating, toileting, and personal hygiene, and was totally dependent on staff for bathing. The MDS coded the resident with impairments of bilateral upper and lower extremities and was at risk for skin breakdown. An updated care plan dated 10/23/16 identified Resident #7 was at risk for skin breakdown. The goal was to have healing of the areas. An intervention included weekly skin assessments and monitoring. A review of the nurse's notes from 08/22/16 through 11/21/16 revealed the following entry which read in part: 09/13/16 at 1:30 PM: Resident #7 had a bruise to the left thigh and to the nose. The resident was examined and noted to have an orange sized hematoma to the left inner mid-thigh area, slightly bluish in color and noted to be approximately 2 centimeters (cm) by	F 309	1. Resident #7 hematoma was resolved on 11/1/16. 2. All residents have the potential to be affected. An audit of incident for the last 90 days was completed on 11/30/16 by the Director of Clinical Operations to identify any other bruises for residents with thrombocytopenia that may require further assessment. Residents with thrombocytopenia were reviewed to ensure no bruising was present or in need of reporting on 11/30/16 by the Director of Clinical Operations and the weekly skin checks were reviewed by the DON on 12/13/16 to ensure the actual reflection of these resident□s. 3. Licensed staff education was initiated by the Director of Nursing (DON) on 12/6/16 regarding documentation of resident assessments, to include weekly skin assessments reflecting current status of resident□s skin, to include identification of any bruising, documentation in the medical record regarding incidents to include suspicious bruising, and notification as appropriate to the MD/RP/DON. Employees not working during the education time frame (i.e. FMLA, PRN); will receive this education prior to their next scheduled shift by the DON/Designee. 4. Audits of the weekly skin assessments for residents with thrombocytopenia will be completed weekly X 6 weeks, then every 2 weeks X 6 weeks, then monthly by the DON/Designee/Unit Managers; to	

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F 309	Continued From page 10 1 cm and on the left side of the nose the area was blue in color. The Physician Assistant (PA) was notified and no new orders were obtained and the resident's representative was also notified. Further review of the nurse's notes revealed the following entries in regards to the injury of unknown origin, a hematoma to the left inner mid-thigh: 09/14/16 at 1:30 PM: Resident with hematoma size of fist on inner left thigh. 09/30/16 at 1:35 PM: apply warm compress to left thigh hematoma for 15 minutes every shift. 10/20/16 at 11:00 AM: no further issue with the hematoma 11/01/16 at 2:25 PM: discontinue treatment to left inner upper thigh, area resolved. A review of the medical record revealed a progress note dated 09/13/16 by the PA which read in part Resident #7 was evaluated in regards to a bruising with hematoma to the left medial thigh area. The PA indicated in the progress note that Resident #7 was cooperative during the exam and seemed concerned that the bruise was there but was unaware of how it had happened. Further review of Resident #7's medical record revealed 2 more progress notes dated the following: 09/14/16: Resident evaluated by the facility's physician for abnormal bruising to the left inner thigh with lesser bruises noted over the arms and lower legs. The resident known to have low platelets as detailed with the last laboratory draw 3 months ago with a platelet count of 98 (normal range 130-400). The physician ordered a laboratory blood draw for the next day. The	F 309	ensure accurate reflections of resident□s skin, to include the identification of any bruising and ongoing documentation in the medical record of such as appropriate. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	

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platelet count on 09/15/16 was 93.

A progress note dated 09/30/16 by the PA read in part Resident #7 was evaluated due to a hematoma to the left leg. The PA ordered warm moist compress for 10 minutes three times a day and to monitor for any worsening of the hematoma.

A review of the weekly skin assessments indicated the following assessments:
09/19/16: bruise to inner left thigh with hematoma size of a fist, swollen
09/26/16: bruises in scattered areas
10/03/16: no description or indication of a bruise to the left thigh
10/10/16: no description or indication of a bruise to the left thigh
10/17/16: bruise to left thigh still present, hot compress as ordered
10/24/16: no bruising found on inner left thigh (healed)

An interview was conducted with Nurse #2 on 11/22/16 at 5:11 PM. Nurse #2 confirmed she was the 2nd shift supervisor on 09/13/16 and she was aware of Resident #7's hematoma. Nurse #2 also confirmed she was responsible for completing the weekly skin assessments for Resident #7. She described skin checks was observing the resident's entire body head to toe for any breakdown or discoloration. Nurse #2 confirmed she had not documented on the weekly skin assessments in regards to Resident #7's left thigh hematoma. She stated she only looked and documented in regards to new skin issues and had not documented about the hematoma since there had been no changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING ______ B. WING ______	C 11/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE REHABILITATION & CARE	306 DEER PARK ROAD NEBO, NC 28761

(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 309	Continued From page 12 An interview was conducted with the interim DON on 11/22/16 at 5:35 PM. The DON stated she was not employed by the facility at the time of the incident and she was unaware of the incident until 11/22/16. The DON confirmed the weekly skin assessments had not addressed the hematoma from 09/26/16 until 10/17/16. The DON also confirmed there was only 3 times a nurse had documented in regards to Resident #7's left inner thigh hematoma and there was no documentation as to indicate why the PA had evaluated Resident #7 on 09/30/16 which was 16 days from the last evaluation by the facility's physician. The DON stated she would have expected an ongoing assessment of Resident #7's hematoma.	F 309		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to	F 520		12/16/16

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F 520	Continued From page 13 coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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: Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2016. This was for one recited deficiency which was originally cited in October of 2016 on a complaint survey and subsequently recited in November of 2016 on a current follow up and complaint survey. The deficiency was in the area to provide care and services to maintain highest well-being. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included:	F 520	1. The facility will ensure the QAPI committee maintains and effective plan to monitor continued compliance of deficiencies identified. Resident #7 hematoma was resolved on 11/1/16. 2. All residents have the potential to be affected. An audit of incident for the last 90 days was completed on 11/30/16 by the Director of Clinical Operations to identify any other bruises for residents with thrombocytopenia that may require further assessment. Residents with thrombocytopenia were reviewed to ensure no bruising was present or in need of reporting on 11/30/16 by the Director of Clinical Operations and the weekly skin checks were reviewed by the DON on	

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F 520

Continued From page 14

This tag is cross referred to:

F-309 Provide care and services to maintain highest well-being. Based on record review and staff interviews the facility failed to assess a hematoma for a resident with a platelet disorder for 1 of 4 sampled residents reviewed for care to maintain well-being (Resident #7).

The facility was recited for F-309 for failing to assess a hematoma for a resident with a platelet disorder (blood clotting disorder). F-309 Provide care and services to maintain highest well-being was originally cited during the October 6, 2016 complaint survey for failing to administer an anti-viral medication for 1 of 4 residents reviewed for care to maintain well-being (Resident #3).

During an interview on 11/22/16 at 6:31 PM the Administrator explained they had just had their November Quality Assessment and Assurance Committee meeting last week. She stated during the meeting they had reviewed the most recent survey deficiencies from the October 2016 survey and the Quality Assurance and Performance Improvement process. She explained they had reviewed the inservices that had been done and the audit tools and discussed how and why the audit tools were used that were specific to the F-309 deficiency. She stated they did not discuss concerns that related to the assessment of a hematoma because it was not specifically cited in the previous survey.

F 520

12/13/16 to ensure the actual reflection of these resident□s.

3. The facility Quality Assurance Performance Improvement committee members were educated by the Director of Clinical Operations on 10/19/16 regarding the revised QAPI process to include the new forms and format. This includes the facility will identify areas for continuous quality monitoring and the monitoring tools to be used. These monitoring activities should focus on those processes that affect resident outcomes most significantly, to include previous survey deficiencies. This ongoing monitoring is used to establish the facility□s baseline and the predictability of various outcomes. Licensed staff education was initiated by the Director of Nursing (DON) on 12/6/16 regarding documentation of resident assessments, to include weekly skin assessments reflecting current status of resident□s skin, to include identification of any bruising, documentation in the medical record regarding incidents to include suspicious bruising, and notification as appropriate to the MD/RP/DON. Employees not working during the education time frame (i.e. FMLA, PRN); will receive this education prior to their next scheduled shift by the DON/Designee.

4. The QAPI Committee will continue to meet on a monthly basis to continue monitoring identified areas of improvement, to include, survey

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F 520	Continued From page 15	F 520	deficiencies for compliance. The QAPI Committee will address the identified area, examine and improved the identified need through improvement (action) plans and monitoring the effectiveness of such plans. The Director of Clinical Operations/Designee will review the facility QAPI Committee meeting minutes monthly until substantial compliance is achieved. Random audits of the weekly skin assessments for will be completed weekly X 6 weeks, then every 2 weeks X 6 weeks, then monthly by the DON/Designee/Unit Managers; to ensure accurate reflections of resident□s skin, to include the identification of any bruising and ongoing documentation in the medical record of such as appropriate. Results of these audits will be taken to the monthly QAPI Committee meeting X 3 months to ensure ongoing substantial compliance.	