STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to make the most recent survey results available for examination by individuals wishing to examine the results without asking to see them. Finding included: An observation on 2/5/17 at 3:45 PM revealed that the most recent survey results were not available for examination. In an interview with the Administrator at 6:00 PM on 2/5/17 he revealed that he had placed the book containing the survey results in his office because he was planning to relocate the book. An observation on 2/6/17 at 10:00 AM revealed that the book containing the most recent survey results was not available for examination without asking. A sign was posted in the main lobby of the facility instructing individuals to ask the receptionist if wishing to examine the most recent	F 167	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 167 A corrective action for affected resident: No specific resident is identified. All current residents desiring to view the survey results have the potential to be affected by the alleged deficient practice.	3/4/17

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

Electronically Signed | 03/03/2017

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F 167	Continued From page 1 survey results. In an interview with the Administrator on 2/7/17 at 5:15 PM he revealed that he had not placed the most recent survey results in an area readily available for individuals to examine because he felt that individuals were taking pages out the book and taking them home. He stated that it was acceptable for him to post a sign instructing individuals to ask to see the survey results. An observation on 2/9/17 at 3:15 PM revealed that the book containing the most recent survey results was not available for examination without asking. A sign remained in the lobby instructing individuals to ask the receptionist if wishing to examine the most recent survey results. In an interview with the Administrator on 2/9/17 at 5:45 PM he revealed that he had not placed the most recent survey results in an area readily available for individuals to examine without asking to see them.	F 167	On 02/10/2017 the Administrator placed a sign in the front foyer directing visitors where to find the survey results. The sign states Survey results and required postings can be found on the front hall located by the fish aquarium. On 03/02/2017, the Nurse Consultant audited to ensure the survey results notice and notebook were available for residents to readily see and examine. The posting and survey results did meet requirements. Systemic changes made were: On 03/02/2017, the Nurse Consultant in-serviced the Administrator on the requirements that the resident has the right to examine the most recent survey of the facility conducted by the Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This information has been integrated into the standard orientation training for all Administrators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Nurse Consultant will monitor this issue using the Survey Posting Quality Assurance Tool for monitoring survey	

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F 167	Continued From page 2	F 167	posting notice and most recent results in the facility. This will be completed monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		3/4/17

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F 279	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to develop a comprehensive care plan to address the use of left arm splints (used to treat contractures) for 1 of 1 sampled residents (Resident #111) reviewed for Range of Motion (ROM). Findings included: Resident #111 was admitted to the facility on 12/1/16. The resident's diagnoses included chronic kidney disease (CKD), end stage dementia, Alzheimer's disease, epilepsy, gastrostomy, dysphagia, hypertension (HTN), and diabetes (DM). Review of the admission Minimum Data Set (MDS) dated 01/11/17 indicated Resident #111 had severe cognitive impairments. Resident #111 was dependent on staff for eating, transfers, dressing, locomotion, bathing, and personal hygiene. Review of the care plan dated 01/9/17 revealed no problem area or intervention implemented for Resident #111's use of splints for contractures. During an interview on 02/9/17 at 3:01 PM, the MDS nurse indicated she did not know why a care plan wasn't developed for the use of splints for left arm contractures for Resident #111. She further revealed, a care plan for contractures and splinting should have been developed. She said Resident #111 was newly admitted from the hospital and that a care plan for the use of splints was overlooked. She indicated that a care plan	F 279	F 279 A corrective action for affected resident: For resident #111, the MDS Coordinator updated the residents care plan to include current contractures and interventions for range of motion and splinting. This was completed on 2/9/17. In addition to this, on 2/9/17, the resident was evaluated by occupational therapy for contracture interventions and splints were ordered, care planned and tasked to the Kardex for the left upper extremity elbow and hand. All current residents with contractures have the potential to be affected by the alleged deficient practice. On 3/1/17, the Support Nurse and Director of Nursing assessed all current residents for contractures. This was completed by performing a physical assessment of all residents and evaluating for resident to move extremities through full range of motion. For residents that contractures were identified, the Nurse Management Team audited the care plans to ensure the contractures are care planned and interventions are included as appropriate. All contractures identified that are not currently being treated with splinting or physical or occupational therapy were reviewed for the need for a therapy evaluation. This process will be completed	

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F 279	Continued From page 4 should have been developed for the use of splints. During an interview on 02/9/17 at 2:45 PM, the Director of Nursing (DON) revealed it was her expectation that the use of splints and contracture management be care planned and monitored for Resident #111, and was not.	F 279	by 3/3/17. Systemic changes made were: On 3/1/17, the MDS Coordinator was in-serviced by the Clinical Nurse Consultant on Care planning Impairments in Functional range of motion and Splint Use. This information has been integrated into the standard orientation training for MDS Coordinators and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Contracture Care Quality Assurance Tool, this tool will audit if the resident is identified with contractures are they care planned and is splinting in place if indicated. This will be completed weekly for 2 weeks monitoring 3 readmissions and 3 randomly chosen residents then monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 315	Continued From page 5	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician Assistant interviews the facility failed to administer an antibiotic for the length of time ordered for 1 of 1 sampled residents (Resident #41) investigated for a urinary tract infection. Findings included: Review of the Quarterly Minimum Data Set (MDS) dated 09/26/16 revealed Resident #41 was admitted to the facility on 03/22/12 with diagnoses of heart failure, hypertension and Alzheimer's disease. Resident #41 was incontinent of bowel and bladder and needed the extensive assistance of two people for toilet use and the extensive assistance of one person for hygiene and bathing. Resident #41 was moderately cognitively impaired. Review of the laboratory Final Report dated 12/07/16 revealed Resident #41 had greater than or equal to 100,000 colonies/ml (millileter) of Escherichia Coli in the urine. A handwritten note	F 315	F315 Corrective Action for Resident Affected On 2/9/17, the Nurse Practitioner was notified by the Nurse Consultant of resident #41 receiving IM Rocephin for 3 days instead of 7. No new orders were given. All current residents receiving antibiotics have the potential to be affected by the alleged deficient practice. All residents who are actively being treated with antibiotic medication will be audited to ensure that he/she is receiving the ordered antibiotic for the time frame ordered by the MD. This was completed by running an Order Listing Report from Point Click Care for all current antibiotics ordered. The list was then reviewed by the	3/4/17

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F 315	Continued From page 6 on the laboratory report dated 12/14/16 and signed by the Physician's Assistant (PA) read: Start Rocephin 500 every day for 7 days IM (intramuscularly). Review of the Doctor's Progress Notes dated 12/14/16 revealed a note written by the PA to start Rocephin 500mg (milligrams) IM every day for 7 days. Review of Resident #41's December 2016 Medication Administration Record (MAR) revealed the Rocephin 500mg IM for 7 days order was transcribed to be given for only 3 days. Resident #41 only received the ordered antibiotic on 12/13/16, 12/14/16, and 12/15/16 instead of the ordered 7 days. In an interview on 02/09/17 at 12:10 PM the Director of Nursing (DON) indicated Nurse #4, who had transcribed the Rocephin order, was on military leave and unavailable for interview. In a telephone interview on 02/09/17 at 4:26 PM the PA stated she expected her orders to be carried out as written. She indicated she expected the Rocephin to have been given for the 7 days she had ordered. In an interview on 02/09/17 at 2:35 PM the Consulting Pharmacist stated if an antibiotic was not given for the full course of the treatment ordered, the organism may not be eradicated. In an interview on 02/09/17 at 5:22 PM the DON stated she expected orders to be transcribed correctly. She indicated that usually the clinical leadership team would have reviewed the order but since it was written on the laboratory report	F 315	nurse managers. The antibiotic order was reviewed for discrepancies and compared to documentation in the residents chart e.g.: lab reports, progress notes, or verbal telephone order forms. The medical provider will be notified of any resident whose antibiotic order is found to be entered incorrectly. This audit was completed on 3/1/17. Systemic Changes On 2/27/17, the Staff Development Coordinator initiated education for all Full-Time, Part-Time and PRN RN□s and LPN□s on the importance of ensuring antibiotic orders are entered for the correct number of days as ordered by the provider to ensure optimal antibiotic coverage for the condition being treated. Any in-house staff member who did not receive in-service training by 3/3/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN□s and LPN□s and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. New antibiotic review procedure: Effective 3/3/17, the Support Nurse with the nurse management team will review all antibiotic orders at a minimum of three days a week. An order report will be run from Point Click Care for antibiotics ordered within the last seven days. Those antibiotics will then be compared to the	

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F 315	Continued From page 7 and not as a telephone order it had not been reviewed. The DON stated that even if not reviewed by the clinical leadership team the order should have been transcribed correctly and Resident #41 should have received the antibiotic for the 7 days as ordered.	F 315	lab reports and MD progress notes to ensure correct transcription of the order. Any clarifications needed will be presented to the MD, Nurse Practitioner, or Physician Assistant. Quality Assurance The Support Nurse will be responsible for auditing five residents receiving antibiotic medication to ensure that residents are receiving the antibiotic for the duration ordered by the provider. This will be done weekly for 2 weeks then monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Director of Nursing in order to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		3/4/17

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F 318	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide a left elbow neuro flex splint and a left resting hand splint with finger separators for 1 of 1 sampled residents (Resident #111) reviewed for contracture management. Findings included: Resident #111 was admitted to the facility on 12/01/16. The resident's diagnoses included chronic kidney disease (CKD), end stage dementia, Alzheimer's disease, epilepsy, gastrostomy, dysphagia, hypertension (HTN), and diabetes (DM). Review of the admission Minimum Data Set (MDS) dated 01/11/17 indicated Resident #111 had severe cognitive impairments. Resident #111 was dependent on staff for eating, transfers, dressing, locomotion, bathing, and personal hygiene. Review of the Certified Nursing Assistant (CNA) care tracker dated 02/05/17 and 02/06/17 revealed that Resident #111 was to "wear left elbow neuro flex splint and a left resting hand splint with finger separators for 6 hours daily, as tolerated." The spaces next to the splints were left blank as not applied. An interview on 02/08/17 at 10:00 AM with the Rehabilitation Director (RD) revealed Resident #111's left arm contracture splinting should have been resumed after his recent hospitalization (11/27/16 - 12/01/16), and was not. She said Resident #111 was assessed by PT/OT (Physical	F 318	F 318 A corrective action for affected resident: For resident #111, a physical therapy evaluation for splinting and contracture management was completed on 2/9/17. New orders were received for right upper extremity elbow and hand splint and put in place on 2/9/17. All current residents who utilize splints have the potential to be affected by the alleged deficient practice. On 3/1/17, the Nurse Management Team assessed all current residents for the use of splint devices. This was completed by doing a chart audit of the resident□s therapy section for any notes pertaining to previous splinting orders. In addition to this, each resident□s room was checked for any splints that may have been packed up or placed in their closet. No unused splints were identified during this review. Systemic changes made were: On 02/27/2017, the Clinical Nurse Consultant initiated education for the Director of Nursing, Staff Development Coordinator, and Support Nurse on the new readmission review procedure for splints review. For all readmissions effective 3/1/17: With each readmission, the Nurse Management Team will review the resident□s previous orders, therapy	

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F 318	Continued From page 9 Therapy/Occupational Therapy) after his return from the hospital on 12/01/16 and nursing should have re-assessed the resident's contractures and resumed his splinting order upon admission back to the facility, and did not. An observation of Resident #111's room on 02/08/17 at 10:10 AM with the RD revealed Resident #111 had two left arm splints in his closet, not being utilized. An interview on 02/08/17 at 10:20 AM with Nursing Assistant (NA) #6 who was assigned to Resident #111 on 02/07/17 and 02/08/17, revealed she never knew Resident #111 had splints or where they might be kept. NA #6 said for the last two days (7AM to 3 PM shift) she worked with Resident #111 and she never applied the splints. When asked to check her electronic NA tracker, it revealed for: "Resident #111 to wear a left elbow neuro flex splint and a left resting hand splint with finger separators for 6 hours daily as tolerated." In an observation on 02/08/17 at 9:30 AM Resident #111 was sitting up in bed resting. He was in a gown, his left elbow and left hand were contracted with no elbow or hand splints. In an observation on 02/09/17 at 8:45 AM Resident #111 was in bed resting. He was in a gown, his left elbow and left hand were contracted with no elbow or hand splints. An interview on 02/08/17 at 3:13 PM with the Rehabilitation Director revealed she never received a request to re-evaluate form for Resident #111 from nursing to request a re-screen and to continue his splinting order for his left arm contractures after returning from the hospital on 12/01/16. The rehab director said	F 318	section, and kardex for splints that need to be reinstated. This process will be documented on the Admission Review Quality Assurance Form. Any Nurse Management Team member who did not receive in-service training by 3/3/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all Nursing Management and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing will monitor this issue using the Contracture Care Quality Assurance Tool for monitoring residents with contractures for care planning and splinting. This will be completed weekly for 2 weeks monitoring 3 readmissions and 3 randomly chosen residents then monthly times 3 months or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 318	Continued From page 10 nursing should have resumed his splinting order after his 11/27/16 through 12/01/16 hospitalization. An interview on 02/08/17 at 3:45 PM with the Director of Nursing (DON), revealed an order for splinting should have been carried over from Resident #111's most recent hospitalization, and was not. The DON said the unit manager nurse who manually transcribed the hospital orders for Resident #111 missed including the left arm splint order. She said it was her expectation that the splint order would have been resumed, and was not.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to use the assigned total lift to transfer a resident from a shower chair to the bed, resulting in a left shoulder dislocation and fracture which required surgery for 1 of 1 sampled residents (Resident #41). Findings included: Review of Resident #41's Quarterly Minimum Data Set (MDS) dated 06/30/16 revealed a	F 323	Past noncompliance: no plan of correction required.	3/3/17

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F 323	Continued From page 11	F 323		

readmission date of 05/30/12 and diagnoses of anemia, heart failure and osteoporosis. Resident #41 was moderately cognitively impaired. Resident #41 needed the extensive assistance of two people for bed mobility and transfers and had no impairment in the functional range of motion in the upper and lower extremities. Resident #41 was alert and able to make her needs known. Resident #41 was not resistant to care.

Review of Resident #41's Care Plan revised 06/30/16 revealed the resident was at risk for falls with the goal of not sustaining serious injury over the next 90 days. An Intervention/Task listed to accomplish this goal was to transfer the resident out of bed with a mechanical lift with two staff. USE BLUE SLING.

Review of the Health Status Note written by Nurse #1 dated 09/07/16 at 3:43 PM and designated as a "Late Entry", revealed Resident #41 had been scheduled to receive a shower on day shift. Nursing Assistant (NA) #1 approached Nurse #1 to request assistance in transferring Resident #41 out of the shower chair after the shower was completed. When Nurse #1 entered Resident #41's room she observed NA #1 attempting to transfer Resident #41 using a "sit to stand" lift. NA #2, who was in training at that time, was also in the room. Nurse #1 informed NA #1 that Resident #41 required the use of a total lift for transfers. Nurse #1 with the assistance of NA #1 and NA #2 transferred Resident #41 to the bed. Resident #41 was assessed by Nurse #1 and denied pain related to the transfer.

Review of the undated and unsigned investigation report showed "under Conclusion": "It was

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determined that the involved employee's use of a stand aide lift to transfer the resident on 09/07/16 instead of the assigned total lift [Brand Name] contributed to the resident's injury."

Review of the Health Status Note dated 09/09/16 at 11:02 AM and designated as a "Late Entry" revealed Resident #41 complained of pain to both arms and both legs and knees that morning. According to the note this was a common complaint for Resident #41 although active participation with care using the left arm was noted to be decreased. There was no difference noted in the length of the arms and pain medications were given.

Review of the Health Status Note dated 09/10/16 at 6:25 PM revealed Nurse #2 noted increased combativeness with staff during care and appeared to have pain to the left shoulder on movement. Pain medication was administered with good result. Resident #41 had no further complaints of pain for several hours. Later in the shift, Resident #41 was noted to be moaning and verbally complained of pain to the left shoulder during care. Pain medications were again administered with good result. Resident #41 received scheduled narcotic pain medication twice each day and also as needed narcotic pain medications.

Review of the Health Status Note dated 09/11/16 at 4:19 AM revealed Nurse #3 noted new swelling to Resident #41's left hand. The arm and hand were elevated on a pillow and pain medication was provided. The pain was relieved and Resident #41 slept for long intervals without complaint of pain.

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Review of the Health Status Note dated 09/11/16 at 6:51 PM revealed Nurse #2 noted Resident #41 continued to be combative with care. Resident #41 also continued to have pain in the left shoulder on movement. Pain medications were administered with positive results. Resident #41 rested quietly throughout the day with no complaints of pain at rest.

Review of the Doctor's Progress Note dated 09/12/16 revealed Resident #41 had been seen by the Family Nurse Practitioner (FNP). The nursing staff had reported that Resident #41 had a cough over the weekend. The note indicated Resident #41 was feeling well and had no complaints. A respiratory assessment was completed.

Review of the Health Status Note dated 09/13/16 revealed Resident #41 complained of increased pain to the left shoulder when moved and repositioned. The FNP was notified and an order for an immediate x-ray was received.

Review of the Doctor's Progress Notes dated 09/13/16 revealed the FNP had seen Resident #41 for a complaint of severe left shoulder pain. Resident #41 was noted to be yelling when touched. No trauma had been noted. There was decreased range of motion to the left shoulder and a new order for a pain patch and a shoulder x-ray were written.

Review of the left shoulder x-Ray report dated 09/13/16 revealed "under Impression:" "Apparent fracture/dislocation type injury."
Review of the Health Status Note dated 09/13/16 at 6:35 PM revealed Resident #41's x-ray results were provided to Resident #41's Physician. The

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Physician requested a visit to the orthopedic clinic for the following morning.

Review of the Health Status Note dated 09/14/16 at 11:32 AM revealed Resident #41 had been seen at the orthopedic clinic and was sent to the hospital Emergency Department from there. Resident #41 was admitted to the hospital and required surgery to the left shoulder.

Review of the Hospital Discharge Summary dated 09/19/16 revealed a discharge diagnosis of a fracture dislocation of the joint of the left shoulder. Resident #41 required surgical intervention to repair the shoulder.

Review of the incident investigation provided by the facility revealed they believed Resident #41's shoulder injury had occurred during the transfer with the sit to stand lift. The Nurse, NA #1 and NA #2 had all provided written statements regarding the incident.

Review of Nurse #1's written witness statement dated 09/14/16 revealed a sit to stand lift had been used by NA #1 for transfer instead of the appropriate total lift. After putting Resident #41 back to bed complaints of pain to the legs and hips were noted. Complaints of pain were not new for Resident #41. The note indicated there were no further complaints of pain from Resident #41 until 09/09/16 when she complained of pain to the left arm. The note indicated Nurse #1 notified the FNP via the communication book.

In an interview on 02/09/17 at 4:05 PM Nurse #1 stated she attempted to help transfer Resident #41 back to bed when she saw the incorrect lift was being used on 09/07/16. She indicated the

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lift strap was under Resident #41's arms and was pulling on the arms. Nurse #1 stated she and the aides disconnected the lift and physically assisted Resident #41 into bed. She stated NA #1 and NA #2 did not ask her which lift Resident #41 used for transfers. Nurse #1 stated she assessed Resident #41 who complained of generalized pain but nothing specific. She indicated this was normal for Resident #41. There was no notification to the physician or family because no injury was noted at that time.

Review of NA #1's written witness statement dated 09/14/16 revealed Resident #41 complained to her of arm pain in the morning so she informed Nurse #1. When NA #1 informed Nurse #1 of Resident #41's pain Nurse #1 told NA #1 that Resident #41 was scheduled for a shower that day and if she needed help with the transfer to let her know. According to the statement, NA #1 asked Nurse #1 which lift to use and was told to use the sit to stand lift.

A telephone interview with NA #1 was attempted on 02/09/17 at 11:52 AM. Contact was not possible.

Review of NA #2's written witness statement dated 09/21/16 revealed NA #2 was observing NA #1 use the sit to stand lift. According to the statement, another aide whom she could not identify, told them to use the sit to stand lift but the strap of the lift kept sliding up Resident #41's back. Resident #41 complained of pain and Nurse #1 made sure there were no injuries.

In an interview on 02/09/17 at 3:40 PM NA #2 verified Resident #41 complained of arm pain after the sit to stand lift was used. She indicated

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she had been in-serviced on lifts and knew two aides were needed for all the lifts. She stated another aide told them to use the sit to stand lift but could not remember the name of the aide. She indicated she was with NA #1 and she did not check the Kardex to verify which lift to use.

In a telephone interview on 02/09/17 at 3:25 PM the FNP stated she had seen Resident #41 on 09/12/16 due to a complaint of cough and congestion. She stated she would have asked the resident about pain and would have addressed the issue at that time if there had been any. She stated she had also seen Resident #41 on 09/13/16 and she did have pain at that time. She confirmed Resident #41 was yelling out and could not stand for the shoulder to be touched and that was why she ordered the x-ray. She indicated she had become upset when she found out there had been an incident with a lift that she was unaware of.

In an interview on 02/09/17 at 5:22 PM the Director of Nursing (DON) stated it was her expectation that staff look at the Master Lift List or the Kardex to see which lift and what size sling to use for residents and she expected them to use what was listed.

Review of the facility Plan of Action dated 09/15/16 for this incident revealed Resident #41 had been sent to the orthopedic clinic on 09/14/16 for evaluation of the left shoulder and was then transferred to the hospital. On 09/15/16 the management team reviewed all the current resident's most recent reviews for type of lift designation. A master lift list was placed at each nursing station. The Nurse Consultant reviewed all Care Plans to ensure lifts were in place. On

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09/15/16 In-servicing began for all Registered Nurses (RN), Licensed Practical Nurses (LPN), Medication Technicians (Med Tech), and NA's who worked full-time, part-time or on as needed basis. The In-servicing included to check the Kardex to make sure the correct lift and correct sling size were used and that 2 assistants were needed to perform a mechanical lift. Staff members who did not receive in-service training after 09/21/16 would not be allowed to work until the training was completed. The in-service training was incorporated into the standard orientation training for nurses, med techs, and NA's. The change was to be reviewed by the Quality Assurance (QA) process to verify it had been maintained. The QA support nurse was to monitor the plan using the QA Tool for Monitoring Transfer Devices weekly for 4 weeks and then monthly for 2 months. 5 transfers were to be observed each time for correct lift and correct technique. The Care Plan for each resident was also to be reviewed.

The Action Plan showed in-servicing of staff had been completed by 09/21/16. Master Lift Lists were seen at the nursing stations. Audits were done and in-servicing had been completed for current staff. New hires were receiving lift information during orientation. The plan was in the QA process for the specified amount of monitoring time.

In an interview on 02/08/17 at 3:44 PM NA #3, who had recently started working at the facility, stated when a sit to stand lift was used for transfers only one aide was needed. If the total lift was used then two aides were needed. She indicated she received a lot of information during orientation and could not remember if she

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F 323	Continued From page 18 received a packet on lifts. In an interview on 02/08/17 at 4:55 PM NA #4, who had been employed at the facility for approximately one year, stated a sit to stand lift could be used with only one person but a total lift needed two people. She indicated she received lift training yearly. NA #4 stated a Master Lift List was available at the nurse's desk and should list the size and color of the lift sling.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to clean two kitchen fans, one of which was blowing into the area where sanitized kitchenware was exiting the dish machine. The facility also failed to cover tea and apple cobbler to prevent contamination, and failed to monitor storage areas to make sure opened and repackaged food items were labeled and dated, refrigerated after opening, and discarded after the use-by date determined by the facility. Findings included:	F 371	F 371 Corrective Action for Resident Affected No specific resident is identified. On 2/8/17, the dietary staff cleaned the two kitchen fans in the dish room and production areas identified during survey. On 2/8/17, the dietary staff covered the tea and apple cobbler. On 2/8/17, the following items identified during the survey were labeled with the use by date: potato	3/4/17

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F 371	Continued From page 19 1. During initial tour of the kitchen, beginning at 4:12 PM on 02/05/17, two wall fans had dirty, dusty blades and back sides. The fan which would have blown into the food preparation area was turned off, but the other fan was blowing into the dish machine area. A follow-up tour of the kitchen began at 9:03 AM on 02/08/17. Two wall fans had dirty, dusty blades and back sides. The fan which would have blown into the food preparation area was turned off, but the other fan was blowing into the dish machine area. Breakfast kitchenware began to be run through the dish machine at 9:22 AM on 02/08/17. The wall fan with dusty blades and back side was still blowing into the dish machine areas as sanitized kitchenware exited the dish machine. At 4:11 PM on 02/08/17 the dietary manager (DM) stated the kitchen fans were not on the current cleaning schedule for the dietary department. She reported the front and back surfaces and blades of the fans were supposed to be cleaned to prevent dust and dirt from flying into food and onto sanitized kitchenware. She commented the fans should be disassembled so all fan surfaces could be cleaned with a soap/water solution followed by a sanitizing solution. At 4:25 PM on 02/08/17 the PM cook stated he thought the maintenance department was cleaning the wall fans in the kitchen. He reported it was important to keep all fans surfaces clean so that food and kitchenware would not be contaminated by dust, dirt, and germs. 2. During initial tour of the kitchen, beginning at	F 371	pearls, light brown sugar, quick cooking oats, crispy onions, and a gravy packet. On 2/8/17, the dietary staff discarded the following food items identified during the survey: teriyaki marinade, mayonnaise, tangy barbeque sauce, egg salad, cheese tortellini, lemonade mix, steak fries, bag of rolls, and a pork loin. Corrective Action for Resident Potentially Affected All residents residing in the facility have the potential to be affected. On 2/26/17 the Dietary Manager completed a Sanitation audit of the kitchen. No negative findings were identified. Systemic Changes The cleaning schedule was modified to include cleaning of the kitchen fans. In-servicing began for all dietary staff FT, PT, and PRN on 2/14/17. The Dietary Manager conducted this in-service. An in-service on Preparing, Storing and Serving Food under Sanitary Conditions was conducted for all FT, PT, and PRN Dietary staff on 3/1/17 by the Registered Dietitian. Any in-house dietary staff who did not receive in-service training by 3/3/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 371	Continued From page 20 4:12 PM on 02/05/17, the tea canister, which was at room temperature to touch, was not covered. At 4:48 PM on 02/05/17 the tea canister remained uncovered. During a follow-up tour of the kitchen on 02/08/17 the tea canister, which was room temperature to touch, and two tray pans of apple cobbler remained uncovered. At 10:00 AM on 02/08/17 a calibrated thermometer was used to check the temperature of the apple cobbler. The thermometer registered 131 degrees Fahrenheit. At 10:05 AM on 02/08/17 the tea canister and the two tray pans of apple cobbler remained uncovered. At 4:11 PM on 02/08/17 the dietary manager (DM) stated food items which were not hot enough to kill bacteria should be kept covered. She reported both the tea canister and the apple cobbler needed to be covered to make sure flies, gnats, dust, and germs did not contaminate the food products. She commented the dietary staff was previously in-serviced to cover food items sitting for long periods of time with aluminum foil, plastic wrap, lids, or parchment paper. At 4:25 PM on 02/08/17 the PM cook stated during in-services the dietary staff was instructed to cover food items with plastic wrap or sheets of parchment paper to avoid contamination from insects, dust, and bacteria. 3. During initial tour of the kitchen, beginning at 4:12 PM on 02/05/17, the spice cabinet in the kitchen contained a 57-ounce carton of potato	F 371	Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be completed 5 days per week for two months and then weekly for one additional month or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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pearls (instant mashed potato flakes), a 32-ounce bag of light brown sugar, a 42-ounce container of quick-cooking oats, and a 24-ounce pouch of crispy onions which were opened, but were without labels and dates to indicate when they were opened. In this same cabinet a gallon container of teriyaki marinade, which was half full, was being stored although the label documented, "Refrigerate after opening." In the walk-in refrigerator a gallon container of mayonnaise and a gallon container of tangy barbecue sauce were opened, but were without labels and dates to indicate when they were opened. The label on a storage container of egg salad documented it was placed in storage on 01/31/17 and was to be disposed of on 02/03/17. In the walk-in freezer a storage bag of cheese tortellini had no label and date on it.

During a follow-up tour of the kitchen, beginning at 10:24 AM on 02/08/17, the spice cabinet in the kitchen contained a 42-ounce container of quick-cooking oats and a 13-ounce gravy packet which were opened, but were without labels and dates to indicate when they were opened. In this same cabinet a gallon container of teriyaki marinade, which was half full, was being stored although the label documented, "Refrigerate after opening." In the dry storage room a 8.6-ounce packet of lemonade mix was opened, but was without a label and date to indicated when it was opened. In the walk-in refrigerator a gallon container of tangy barbecue sauce was opened, but was without a label and date. In the walk-in freezer a bag of steak fries and a bag of rolls were opened, and a pork loin was repackaged without labels and dates.

At 4:11 PM on 02/08/17 the dietary manager (DM)

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stated any member of the dietary staff who opened food items without utilizing all of them was responsible for placing labels and dates on them. She also reported leftovers and food items which were removed from their original packaging were supposed to have labels and dates on them. She explained the labeling/dating system helped ensure older food items got used up first and helped ensure leftovers were discarded when they exceeded three days of storage. According the DM, she tried to monitor the storage areas daily to make sure stored food items were properly labeled and dated, old leftovers were disposed of, and labeling about the storage of food items was followed.

At 4:25 PM on 02/08/17 the PM cook stated dates and labels needed to be placed on opened food items, repackaged food items, and leftovers. He reported labeling and dating opened food items helped make sure they were served at their freshest. He also commented keeping leftovers past three days of storage and not refrigerating food items whose labels documented refrigeration after opening was necessary posed the risk of spoilage which could make residents sick. The cook stated all dietary employees were responsible for monitoring storage areas as they went in and out of them on a daily basis.