STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING _____ B. WING _____	C 04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

(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 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 4/18/17 through 4/23/17 and 4/26/17. On 4/26/17 an interview occurred with the Paramedic who arrived on the scene for Resident #67. An extended survey was conducted. Immediate Jeopardy was identified at: CFR 483.10 at tag F155 at a scope and severity (J) CFR 483.13 at tag F224 at a scope and severity (J) CFR 483.25 at tag F309 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) The tags F224, F309 and F323 constituted Substandard Quality of Care. Immediate Jeopardy for tags F155, F224 (Example #1) and F309 began on 4/5/17 and was removed on 4/22/17. Immediate Jeopardy for tag F224 (Example #2) began on 4/10/17 and was removed on 4/22/17. Immediate Jeopardy for tag F323 began on 4/10/17 and was removed on 4/22/17.	F 000		
F 155 SS=J	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 155		6/5/17

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

Electronically Signed | 05/19/2017

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F 155	Continued From page 1	F 155		

to participate in experimental research, and to formulate an advance directive.

c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he

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F 155	Continued From page 2 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and paramedic interview the facility failed to initiate any care to a resident (Resident #67) that was gasping for air after eating an ice cream cone before emergency medical services arrived. Immediate jeopardy began on 4/5/17 when Resident #67 was out of the facility on an activity outing to a local ice cream shop and began gasping for air after eating an ice cream cone. The nursing home staff left the resident unattended and did not initiate emergency medical services immediately. Resident #67 required treatment by Emergency Medical Services (EMS) and was hospitalized. The immediate jeopardy was removed on 4/22/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings Included:	F 155	F155: A. On 4/5/17 Resident # 67 went on an outing with activity assistant and two interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, intern called 911, emergency personnel arrived noted the resident with agonal breathing. Emergency Medical Service (EMS) initiated emergency protocol which included bagging the resident. Resident #67 was transported to the hospital by EMS. Activity assistant was educated by the Staff Development Coordinator on 4/22/17 on identifying an emergency situation which included recognizing an emergency situation episode that maybe characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging, calling 911 immediately and staying with the resident. B. All other residents that went on the outing were assessed by the Director of Nursing (DON), Assistant Director of	

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F 155	Continued From page 3 Resident #67 was admitted to the facility on 9/12/12 and her diagnoses included spasmodic torticollis (a chronic neurological movement disorder causing the neck to involuntarily turn to the left, right, upwards, and/or downwards), dysphagia and postural abnormalities. A review of the April 2017 physician orders for Resident #67 revealed an order for full code status (all resuscitation measures will be performed). A quarterly minimum data set (MDS) dated 2/10/17 for Resident #67 revealed her cognition was intact and she required supervision and one person physical assist with eating. An entry in the nursing notes dated 1/27/17 revealed Resident #67 had an episode of choking while taking her medications which were crushed in vanilla pudding. Code blue was called and cardiopulmonary resuscitation (CPR) was initiated. She was able to start breathing normally again. An order was received to obtain a chest x-ray which came back negative for aspiration. An entry in the nursing notes on 4/5/17 revealed Resident #67 was on an outing today with activities. No nurse was made aware that resident was going. Scheduled pm meds held until return. An entry in the nursing notes on 4/5/17 revealed Resident #67 was sent by ambulance to the hospital from an activity outing at a local ice cream shop due to potential aspiration. A review of the EMS patient care report dated 4/5/17 for Resident #67 revealed that they arrived	F 155	Nursing (ADON), Unit Managers, Nursing Supervisor or Charge nurse by 4/22/17 to ensure that they had not been negatively affected and had no health or safety concerns. No other concerns were identified. All current residents that reside in the facility could be affected by this deficient practice at any time. Residents currently residing in the facility were assessed for any signs and symptoms of distress by the Director of Nursing, Staff Development Coordinator, Charge Nurse, or Regional Nurse Consultant on 4/22/17 for any possible need for emergency medical assistance. No residents were identified with the need for emergency services. C. Change of condition policy was reviewed on 4/21/17 regarding life threatening events which may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging. Education was initiated on 4/21/17 regarding the policy to Administrator, nursing staff, nursing assistants, business office staff, rehabilitation staff, dietary staff, maintenance, housekeeping and activities staff by the Staff Development Coordinator, Director of Nursing, or Regional Nurse Consultant regarding the immediate notification of emergency services by dialing 911 in an emergency situation for a resident. Staff members that are on an outing will be required to have a cell phone at all times. Staff education also included remaining with	

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F 155	Continued From page 4 at the ice cream shop at 2:45 pm. The report stated that EMS was dispatched for cardiac arrest. The Fire Rescue (FR) arrived on scene prior to ambulance and obtained history of the event from bystanders (the facility Activity Assistant and intern volunteer). Patient (Resident #67) had just gotten ice cream with a group from her care facility when her bystanders stated she became apneic (temporary suspension of breathing) and unresponsive. CPR was initiated by bystanders at that time. FR arrived at the scene and found the patient breathing but responsive only to painful stimuli and discontinued CPR. At that time FR placed resident on 10 liters of oxygen and status post oxygen saturation level was 90%. Patients baseline level of responsiveness was not known, but "better than this" per bystanders. Per FR bystanders knew very little about resident. Assessment of patient by Medic revealed upon arrival patient was sitting in her wheelchair. She was non-verbal and responsive to painful stimuli. Her breathing was shallow and abnormally slow with a respiration rate of 8 per minute. She had strong radial pulses present and her skin appeared pale and waxy. Treatments administered to patient were documented as placement on 10 liters of oxygen, respirations assisted via bag valve mask, administration of 5 milligrams (mg) of albuterol, intravenous administration of 300 cubic centimeters (cc) of normal saline and transport to the hospital emergency department. A phone interview was conducted with Paramedic #1 on 4/26/17 at 10:40 am. She confirmed that she had responded to the call on 4/5/17 at the ice cream parlor for Resident #67. She stated that when she arrived on the scene Resident #67 was	F 155	the resident until the arrival of Emergency Management Services personnel. Licensed Nursing staff are certified in the Heimlich maneuver. All staff were notified by the Staff Development Coordinator or Human Resources on 4/21/17 that they could not work until receiving above education. Education regarding the above stated policies and procedures along with processes will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education has been obtained. D. Director of Nursing, Staff Development Coordinator, ADON□s or Regional Nurse Consultant will audit Activity Monitoring Tool prior to the next four outings. The Activity Outing audit tool consist of (Physician Summary Sheet which contains the resident□s diet, liquid consistency, and code status) the tool also list cell phone on hand, Licensed Nurse/ADON/DON that approved the outing and approval of Quality of life Director (QOL. The Activity Monitoring Tool will be completed by the Quality of Life Director prior to the outing. A Quality Assurance meeting will begin on 5/4/17 to ensure compliance, then weekly for 4 weeks, then monthly x 2 months for further follow up regarding the above stated plan. At that time based upon evaluation of the findings the QA Committee will determine at what frequency any ongoing audits, continued education or revision of plan will need to continue. A nurse from the regional team	

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F 155	Continued From page 5 sitting in her wheelchair and was minimally responsive. She stated that Resident #67 looked very bad. She stated that she had been started on oxygen and intravenous fluids. She stated that Resident #67 required manual help with respirations and that was conducted during the ambulance trip to the hospital. She stated that she did not observe the resident receiving CPR and that it was not indicated because Resident #67 was breathing, not well, but was breathing and did not require CPR. She stated that she did not observe that the resident was choking and did not perform any suctioning or treatment for that. She stated that she was concerned that the facility staff members that were with Resident #67 did not seem to know anything about her health condition and they were trying to get someone from the facility to bring her medical records. She stated that it was 5 to 10 minutes before anyone from the facility arrived with her medical records. A review of the hospital admission records dated 4/5/17 for Resident #67 revealed she presented unresponsive in the emergency room. It stated that Resident #67 was at an ice cream parlor on 4/5/17 with her friends from her facility when she suddenly became unresponsive. She received bystander CRP - unknown if she ever lost a pulse. When EMS arrived, she had a respiration rate of 5 and was bagged for 3-4 minutes. A review of the hospital discharge summary dated 4/8/17 for Resident #67 revealed a diagnosis of septic shock secondary to a urinary tract infection (UTI). An interview on 4/20/17 at 10:30 am with the Activity Director revealed that she was not working at the facility on 4/5/17. She stated that	F 155	or corporate office has been onsite since 4/21/17 and will remain on site daily until 4/22/17, then onsite 3 times weekly for 4 weeks. The nurses from the regional team or home office are reviewing compliance with above stated plan along with reviewing compliance with policy and procedure of any Emergent Event that occurs and reviewing compliance. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing and ensure resident rights are being honored as well as an effective plan to identify concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of Regional staff weekly times 4 weeks, then monthly times two.	

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when she returned to work on 4/6/17 she learned that the Activity Assistant and 2 volunteers had taken Resident #67 on an outing to the ice cream shop on 4/5/17. She stated that they had written statements of the incident and the statements were provided to the Director of Nursing (DON). She stated that typically when residents are taken out of the facility for an activity she would provide a list of residents that were going to the DON. She stated that a nurse or nursing assistant (NA) did not always accompany them on the outings and that it depended on the type of outing they were going on. She stated that the Activity Assistant and the intern volunteers went through general orientation when they started at the facility.

An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed she had been on the outing with Resident # 67 on 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17 and decided to take a few residents to the ice cream shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 ordered butter pecan ice cream in a waffle cone and they all sat outside to eat their ice cream. She stated Resident #67 did not appear to have any trouble eating her ice cream cone. When they finished they started to walk back to the facility as it was national walking day (Resident #67 and the other 2 residents were in wheel chairs and the activity assistant and 2 volunteers were pushing them). She stated that Resident #67 started to gasp for air and she asked her if she needed something to drink and Resident #67 said yes. The Activities Assistant went to a drugstore to get her a bottle of water which took approximately 5 minutes. She stated

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when she came out of the store Resident #67 was opening her mouth, gasping for air, was not able to speak and seemed to be less responsive. She stated one of the interns was calling 911 and the 911 operator asked for medical information about Resident #67. She called the facility to try and get the information. She stated the 911 operator told them to try and get her laying down and they were able to lay her wheelchair back. She stated EMS arrived and they placed a tube down her throat and sucked out a piece of waffle cone. A nursing assistant from the facility arrived about 5 to 10 minutes after she had called the facility and then a nurse from red hall came (didn ' t know her name). She stated that Resident #67 seemed fine all day. She stated that she had not let Resident #67 ' s nurse know that she was taking her out. She stated that she did not have any training in emergency medical response.

A review of the "Off-Premise Activities" policy provided by the Activity Director on 4/20/17 revealed procedure #3 stated "At least one or more members of nursing services will accompany the activity director / coordinator on field trips."

An interview with the DON on 4/20/17 at 4:20 pm revealed that she was not in the facility on 4/5/17 and was not aware of the details of what happened with Resident #67 that day. She referred me to the Unit Manager #1.

An interview with Unit Manager #1 on 4/20/17 at 4:32 pm revealed that she was returning to the facility from her lunch break on 4/5/17 and a facility staff member (could not remember who) stopped her and told her that Resident #67 was unresponsive down the street at the ice cream

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shop. She stated she obtained Resident #67 ' s medical information and brought it to the EMS staff. She stated Resident # 67 had already been put in the ambulance by that time. She provided the medical information, including that she was a full code, to EMS. She stated that she was not aware of any further interventions or follow-up by the facility after the incident.

An interview on 4/21/17 at 1:00 pm with the activities intern / volunteer revealed that she had accompanied Resident #67 on the outing to the ice cream shop. She stated that everyone had finished their ice cream and they were walking the residents back to the facility when Resident #67 was gasping for air. She stated that the Activity Assistant went to get Resident #67 something to drink. While she was gone Resident #67 seemed to be getting worse and she called 911. She stated the resident did not stop breathing. She stated that she had been volunteering at the facility since January 2017 and that she did attend the facility general orientation. She stated that she did not receive any training at the facility on emergency medical response or the Heimlich maneuver.

The facility new hire orientation agenda, provided by the Staff Development Coordinator, was reviewed. The general orientation agenda for all staff (Parts 1 and 2) did not include training in the areas of CPR, Heimlich maneuver or medical emergency response. Parts 3 and 4 of the general orientation agenda did include training in CPR and the Heimlich maneuver, this was for Nurses and Nursing Assistants.

An interview on 4/21/17 at 2:00 pm with the Staff Development Coordinator revealed that the

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activity staff are not trained in the Heimlich technique or how to respond in medical emergencies because they don ' t work in a clinical capacity. She stated that volunteers do attend the facility general orientation, but this does not include any medical emergency training such as the Heimlich maneuverer.

A follow-up interview on 4/21/17 at 2:30 pm with the Assistant Activity Director revealed that she had not received any training on the Heimlich maneuver or any emergency medical training.

An interview on 4/21/17 at 3:45 pm with the Administrator revealed that he was somewhat aware of the incident that occurred on 4/5/17 involving Resident #67. He stated that they had discussed Resident #67 ' s swallowing difficulty the next day in the morning meeting. He stated that this was an isolated incident and that no additional investigation was completed. He stated that he assumed that the Activity Assistant and the intern volunteers went through general orientation, but that he was not the Administrator at that time. He was not aware of any other training in the area of emergency medical response for them.

On 4/21/17 at 4:25 pm, the administrator was informed of the immediate jeopardy.

The facility provided a credible allegation on 4/23/17 at 2:00 pm. The allegation of compliance indicated:

On 4/5/17 Resident # 67 went on outing with activity assistant and two interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, intern

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called 911, emergency personnel arrived noted the resident with agonal breathing. EMS initiated emergency protocol which included bagging the resident. Resident #67 was transported to the hospital by EMS. Activity assistant was educated by the Staff Development Coordinator on 4/22/17 on identifying an emergency situation which included recognizing an emergency situation episode that maybe characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging, calling 911 immediately and staying with the resident.

All other residents that went on the outing were assessed by the DON, ADON, Unit Managers, Nursing Supervisor or Charge nurse by 4/22/17 to ensure that they had not been negatively affected and had no health or safety concerns. No other concerns were identified. All current residents that reside in the facility could be affected by this deficient practice at any time. Residents currently residing in the facility were assessed for any signs and symptoms of distress by the Director of Nursing, Staff Development Coordinator, Charge Nurse, or Regional Nurse Consultant on 4/22/17 for any possible need for emergency medical assistance. No residents were identified with the need for emergency services

Change of condition policy was reviewed on 4/21/17 regarding life threatening events which may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging. Education was initiated on 4/21/17 regarding the policy to Administrator, nursing staff, nursing assistants, business office staff, rehabilitation

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F 155	Continued From page 11	F 155		

staff, dietary staff, maintenance, housekeeping and activities staff by the Staff Development Coordinator, Director of Nursing, or Regional Nurse Consultant regarding the immediate notification of emergency services by dialing 911 in an emergency situation for a resident. Staff members that are on an outing will be required to have a cell phone at all times. Staff education also included remaining with the resident until the arrival of Emergency Management Services personnel. Licensed Nursing staff are certified in the Heimlich maneuver. All staff were notified by the Staff Development Coordinator or Human Resources on 4/21/17 that they could not work until receiving above education. Education regarding the above stated policies and procedures along with processes will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education has been obtained.

The credible allegation was verified on 4/23/17 at 5:02 PM. The Activity Assistant was interviewed on 4/23/17 at 4:16 PM and was able to describe the education she received. Assessments of the residents who attended the activity, as well as those who had not attended the activity were reviewed. Communication forms (SBAR) were created for every resident that was assessed. The change of condition policy was reviewed and it was noted life threatening events were defined. In-service topics included elder outings and emergency events. Sign-in sheets. Random staff in the nursing home including a unit secretary, licensed nurse, nurse aide/activity assistant were interviewed between 4:32 PM and 4:56 PM to confirm they had received in-services. The Staff Development Coordinator was

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F 155	Continued From page 12 interviewed to confirm there was a system to train all staff prior to reporting to duty. The immediate jeopardy was removed on 4/22/17.	F 155		
F 224 SS=J	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and paramedic interview the facility neglected to provide immediate emergency medical services for a resident (Resident #67) that was gasping for air and becoming less responsive. The facility failed to identify the cause of the front door alarm being activated as a resident with exit-seeking behavior exited the building for 1 of 1 sampled resident (Resident #166) identified to be at risk for elopement.	F 224	F224: A. On 4/10/17 at 2156, Resident #166 was observed outside the facility on the sidewalk near the rehab side of the building. It was determined that the door alarm had sounded as resident #166 exited the facility. Nurse #1 heard the alarm sounding, but did not attempt to identify the cause of the alarm, and silenced the alarm utilizing a reset button	5/31/17

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F 224	Continued From page 13 Immediate jeopardy began on 4/5/17 when Resident #67 was out of the facility on an activity outing to a local ice cream shop. After consuming the ice cream cone she began gasping for air and becoming less responsive. The nursing home staff left the resident unattended and did not initiate emergency medical services immediately. The immediate jeopardy was removed on 4/22/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. The findings included: 1) Resident #67 was admitted to the facility on 9/12/12 and her diagnoses included spasmodic torticollis (a chronic neurological movement disorder causing the neck to involuntarily turn to the left, right, upwards, and/or downwards), dysphagia and postural abnormalities. A quarterly minimum data set (MDS) dated 2/10/17 for Resident #67 revealed her cognition was intact and she required supervision and one person physical assist with eating. A care plan dated 1/24/17 revealed Resident #67 was active and at risk for behavior problems as evidenced by refusal to follow Medical Doctor (MD)/Nurse Practitioner (NP) orders related to dysphagia due to neuralgia. Resident #67 refused diet texture downgrade and a swallow study. The goal was that Resident #67 would have fewer episodes of choking/aspiration as evidenced by	F 224	at the nurses station. Nurse #1 was suspended pending investigation on 4/21/2017. A skin assessment was completed for Resident #166 on 4/10/17 with no injury identified. The physician and responsible party was notified by Charge Nurse on 4/10/2017. Resident #166 was placed on every one hour monitoring by the charge nurse. On 4/5/17 Resident # 67 went on outing with activity assistant and two interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, leaving Resident # 67 with interns, intern called 911, emergency personnel arrived, suctioned Resident # 67, applied O2 and bagged due to agonal breathing and Resident #67 was transported to the hospital by EMS. Resident # 67 chart and care plan was reviewed on 4/21/17 by the Director of Nursing (DON) or Regional Nurse to ensure resident s quality of care and quality of life were being met. No other concerns identified. B. All residents have the potential to be affected by this deficient practice. A head count was completed on 4/11/17 at 12:00 am for the entire facility by the charge nurse to ensure no other residents were affected by the potentially negligent behavior. All residents were accounted for and safe. On 4/11/17, 8 resident wander guards were checked for placement and functioning by the charge nurse and the central supply clerk. All were found to be in place and functioning properly. No other potential areas of neglect were identified.	

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F 224	Continued From page 14 behavior occurring less than weekly. Interventions included report to physician changes in behavioral status. Anticipate care needs and provide for the resident. Refer to Registered Dietitian (RD) and Speech Therapist (ST) as needed. A review of the April 2017 physician ' s orders for Resident #67 revealed she was a full code (intercede if a patient's heart stops beating or if the patient stops breathing). An entry in the nursing notes dated 1/27/17 revealed Resident #67 had an episode of choking while taking her medications which were crushed in vanilla pudding. Code blue was called and cardiopulmonary resuscitation (CPR) was initiated. She was able to start breathing normally again. An order was received to obtain a chest x-ray which came back negative for aspiration. A telephone interview on 4/21/17 at 9:45 am with the ST that treated Resident #67 revealed she had last treated her in late January for about a week. She stated that Resident #67 had a history of choking. An entry in the nursing notes on 4/5/17 revealed Resident #67 was sent by ambulance to the University of North Carolina (UNC) hospital from an activity outing at an ice cream shop due to potential aspiration. A review of the emergency medical services (EMS) patient care report dated 4/5/17 for Resident #67 revealed that they arrived at local ice cream shop at 2:45 pm. The report stated that EMS was dispatched for cardiac arrest. The Fire Rescue (FR) arrived on scene prior to ambulance	F 224	All residents have the potential to be affected by this deficient practice. Situation with Resident #67 was reviewed with Activity Director on 4/6/17, by the Director of Nursing. Change in condition policy regarding life threatening events were reviewed with the activity assistant on 4/22/17 by the Staff Development Coordinator. Starting on 4/21/2017 Staff Development coordinator, Assistant Director of Nursing (ADON), Regional Nurse Consultant and Regional team reviewed the policy and procedure regarding life threatening events, to include an episode that may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging and proper emergency protocols with priority of who to call first, call 911 immediately. All residents currently residing in the facility were assessed for any signs and symptoms of distress by the Director of Nursing, Staff Development Coordinator, Charge Nurse and/or the Signature Care Consultant, on 4/22/17, for any possible need for emergency medical assistance. No residents were identified with the need for emergency services. C. The Staff Development Coordinator and Social Worker educated the Administrator, DON, ADON, Minimum Data Coordinator (MDS), Dietary Manager, Business Office Manager, Payroll Administrative Assistant, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant	

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F 224	Continued From page 15 and obtained history of the event from bystanders (the facility Activity Assistant and intern volunteer). Patient (Resident #67) had just gotten ice cream with a group from her care facility when her bystanders stated she became apneic (temporary suspension of breathing) and unresponsive. Cardiopulmonary resuscitation (CPR) was initiated by bystanders at that time. FR arrived at the scene and found the patient breathing but responsive only to painful stimuli and discontinued CPR. At that time FR placed resident on 10 liters of oxygen and status post oxygen saturation level was 90%. Patients baseline level of responsiveness was not known, but "better than this" per bystanders. Per FR bystanders knew very little about resident. Assessment of patient by Paramedic revealed upon arrival patient was sitting in her wheelchair. She was non-verbal and responsive to painful stimuli. Her breathing was shallow and abnormally slow with a respiration rate (RR) of 8 per minute. She had strong radial pulses present and her skin appeared pale and waxy. Treatments administered to patient were documented as placement on 10 liters of oxygen, respirations assisted via bag valve mask, administration of 5 milligrams (mg) of albuterol, intravenous administration of 300 cubic centimeters (cc) of normal saline and transport to the hospital emergency department. A phone interview was conducted with Paramedic #1 on 4/26/17 at 10:40 am. She confirmed that she had responded to the call on 4/5/17 at the ice cream parlor for Resident #67. She stated that when she arrived on the scene Resident #67 was sitting in her wheelchair and was minimally responsive. She stated that Resident #67 looked very bad. She stated that she had been started	F 224	Operations Director, Quality of Life Director, and Environmental Services Director starting on 4/11/17 and 4/13/17 regarding the abuse/neglect policy, and responding immediately to door alarms to ensure resident safety. A post-test regarding the abuse/neglect policy was administered to the above stated department managers. Once the facility Administrator, Director of Nursing, Assistant Director of Nursing , Minimum Data Set Coordinators, Staff Development Coordinator, Dietary Manager, Business office manager, Payroll/Administrative Assistant, Social Services Director, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operation, Quality of Life, and Environmental Services were educated and received 100% on the abuse policy and procedure post-test, they were assigned to educate nursing, nursing assistants, dietary, maintenance, housekeeping staff regarding the abuse/neglect policy and procedure, and responding immediately to door alarms to ensure resident safety. All staff will complete a post-test regarding the abuse/neglect policy and procedure education. Staff will not be allowed to work until the education is received and a score of 100% has been obtained on the posttest. If stakeholder did not score 100% on post-test, then stakeholder was immediately re-educated and post-test re-administered. This process continued until all stakeholders obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Regional	

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F 224	Continued From page 16 on oxygen and intravenous fluids. She stated that Resident #67 required manual help with respirations and that was conducted during the ambulance trip to the hospital. She stated that she did not observe the resident receiving CPR and that it was not indicated because Resident #67 was breathing, not well, but was breathing and did not require CPR. She stated that she did not observe that the resident was choking and did not perform any suctioning or treatment for that. She stated that she was concerned that the facility staff members that were with Resident #67 did not seem to know anything about her health condition and they were trying to get someone from the facility to bring her medical records. She stated that it was 5 to 10 minutes before anyone from the facility arrived with her medical records. A review of the hospital admission records dated 4/5/17 for Resident #67 revealed she presented unresponsive in the emergency room. It stated that Resident #67 was at an ice cream parlor on 4/5/17 with her friends from her facility when she suddenly became unresponsive. She received bystander CRP - unknown if she ever lost a pulse. When EMS arrived, she had a RR of 5 and was bagged for 3-4 minutes. A review of the hospital discharge summary dated 4/8/17 for Resident #67 revealed a diagnosis of septic shock secondary to a urinary tract infection (UTI). An interview on 4/20/17 at 10:30 am with the Activity Director revealed that she was not working at the facility on 4/5/17. She stated that when she returned to work on 4/6/17 she learned that the Activity Assistant and 2 volunteers had taken Resident #67 on an outing to the ice cream	F 224	Nurse Consultant, Regional Team, DON, ADON, Staff Development Coordinator or Administrator. The Staff Development Coordinator and Social Worker educated the Administrator, DON, ADON, MDS Coordinators, Dietary Manager, Business Office Manager, Payroll Administrative Assistant, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operations Director, Quality of Life Director, and Environmental Services Director starting on 4/22/17 regarding the abuse/neglect policy, and responding to Life threatening situations. A post-test regarding the abuse/neglect policy was administered to the above stated department managers. Once the facility Administrator, DON, ADON, MDS coordinators, Staff Development Coordinator, Dietary Manager, Business office manager, Payroll/Administrative Assistant, Social Services Director, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operation, Quality of Life, and Environmental Services were educated and received 100% on the abuse policy and procedure post-test, they were assigned to educate nursing, nursing assistants, dietary, maintenance, housekeeping staff regarding the abuse/neglect policy and procedure, and responding immediately to life threatening events to include an episode that may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging and proper emergency	

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F 224	Continued From page 17 shop on 4/5/17. She stated that they had written statements of the incident and the statements were provided to the Director of Nursing (DON). She stated that typically when residents are taken out of the facility for an activity she would provide a list of residents that were going to the DON. She stated that a nurse or nursing assistant (NA) did not always accompany them on the outings and that it depended on the type of outing they were going on. A review of the "Off-Premise Activities" policy dated August, 2007; revision date January 2009 provided by the Activity Director on 4/20/17 revealed procedure #3 stated "At least one or more members of nursing services will accompany the activity director / coordinator on field trips." An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed she had been on the outing with Resident # 67 on 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17 and decided to take a few residents to the ice cream shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 ordered butter pecan ice cream in a waffle cone and they all sat outside to eat their ice cream. She stated Resident #67 did not appear to have any trouble eating her ice cream cone. When they finished they started to walk back to the facility as it was national walking day (Resident #67 and the other 2 residents were in wheelchairs and the activity assistant and 2 volunteers were pushing them). She stated that Resident #67 started to gasp for air and she asked her if she needed something to drink and Resident #67 nodded yes. The Activities Assistant went to a drugstore to get her a bottle of water	F 224	protocols with priority of who to call first, call 911 immediately. All staff will complete a post-test regarding the abuse/neglect policy and procedure education. Staff will not be allowed to work until the education is received and a score of 100% has been obtained on the posttest. If stakeholder did not score 100% on post-test, then stakeholder was immediately re-educated and post-test re-administered. This process continued until all stakeholders obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Regional Nurse Consultant, Regional Team, DON, ADON, Staff Development Coordinator or Administrator. D. Staff post-test regarding the abuse policy and procedure is being administered daily, starting on 5/17/2016 by Administrator, DON, ADON, MDS coordinator, Staff Development Coordinator, Director of Dining Services, Business office manager, Payroll/Administrative Assistant, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operation, Quality of Life, or Environmental Services to 5 different staff members daily x 2 weeks, then 3 staff members 3 times a week for 2 weeks, then 1 staff member weekly times 2 week. If an employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. Results of the staff post-tests will be reported to the Quality Assurance Performance Improvement	

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F 224	Continued From page 18 which took approximately 5 minutes. She stated when she came out of the store Resident #67 was opening her mouth, gasping for air, was not able to speak and seemed to be less responsive. She stated the intern volunteer was calling 911 and the 911 operator asked for medical information about Resident #67. She called the facility to try and get the information. She stated the 911 operator told them to try and get her laying down and they were able to lay her wheelchair back. She stated EMS arrived and they placed a tube down her throat and sucked out a piece of waffle cone. A nursing assistant from the facility arrived about 5 to 10 minutes after she had called the facility and then a nurse from red hall came (didn ' t know her name). She stated that Resident #67 seemed fine all day. She stated that she had not let Resident #67 ' s nurse know that she was taking her out. She stated that she did not have any training in emergency health procedures. An interview on 4/20/17 at 1:30 pm with Nurse #3 revealed she was the nurse for Resident #67 on 4/5/17. She stated that the resident had been fine all day. She stated that she went to find her to provide her afternoon medications and found out that activities had taken her out to get ice cream. She stated that they didn ' t even tell her that they were taking her out. She stated that "everyone "(did not elaborate on who "everyone" was) knew that Resident #67 had trouble swallowing and had choked once or twice in the past. An interview with the DON on 4/20/17 at 4:20 pm revealed that she was not in the facility on 4/5/17 and was not aware of the details of what happened with Resident #67 that day. She	F 224	(QAPI) committee weekly by the Director of Nursing to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QAPI committee will determine at what frequency the staff questionnaire will need to continue. A Quality Assurance Performance Improvement meeting will be held weekly times 4 weeks with the Medical Director, Administrator, Director of Nursing, Social Services Director, Dietary Director, Quality of Life Director, Admissions Coordinator, a Charge Nurse, a Nursing Assistant and the Maintenance Director, to ensure continued compliance with the corrective action plan and for further recommendations as indicated. Quality Assurance/Performance Improvement will be held weekly times 4 weeks then monthly for 2 months for recommendations and further follow up regarding the above stated plan.	

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referred me to the Unit Manager #1.

An interview with Unit Manager #1 on 4/20/17 at 4:32 pm revealed that she was returning to the facility from her lunch break on 4/5/17 and a facility staff member (could not remember who) stopped her and told her that Resident #67 was unresponsive down the street at the ice cream shop. She stated she obtained Resident #67 ' s medical information and brought it to the EMS staff. She stated Resident # 67 had already been put in the ambulance by that time. She provided the medical information, including that she was a full code, to EMS. She stated that she was not aware of any further interventions or follow-up by the facility after the incident.

An interview on 4/21/17 at 1:00 pm with the activities intern / volunteer revealed that she had accompanied Resident #67 on the outing to the ice cream shop. She stated that everyone had finished their ice cream and they were walking the residents back to the facility when Resident #67 started gasping for air. She stated that the Activity Assistant went to get Resident #67 something to drink. While she was gone Resident #67 seemed to be getting worse and she called 911. She stated the resident did not stop breathing. She stated that she had been volunteering at the facility since January 2017 and that she did attend the facility general orientation. She stated that she did not receive any training at the facility on emergency medical response.

A follow-up interview on 4/21/17 at 2:30 pm with the Assistant Activity Director revealed that she had not received any training on the Heimlich maneuver or any emergency medical training.

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A review of the statements dated 4/5/17 written by the Activity Assistant and the activities intern volunteers provided by the DON confirmed the events as obtained in their interviews.

An interview on 4/21/17 at 2:00 pm with the Staff Development Coordinator revealed that the activity staff are not trained in the Heimlich technique or how to respond in medical emergencies because they don ' t work in a clinical capacity. She stated that volunteers do attend the facility general orientation, but this does not include any medical emergency training such as the Heimlich maneuverer.

An interview on 4/21/17 at 3:45 pm with the Administrator revealed that he was somewhat aware of the incident that occurred on 4/5/17 involving Resident #67. He stated that they had discussed Resident #67 ' s swallowing difficulty the next day in the morning meeting. He stated that this was an isolated incident and that no additional investigation was completed.

On 4/21/17 at 4:25 pm, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 4/23/17 at 2:00 pm. The allegation of compliance indicated:
On 4/5/17 Resident # 67 went on outing with activity assistant and two interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, leaving Resident # 67 with two activity interns, one intern called 911. EMS arrived, suctioned Resident # 67, applied O2 and bagged resident, and transported Resident # 67 to Hospital. Resident was admitted to hospital.
All residents on the outing were assessed for any

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change in condition by the DON, ADON, on 4/5/17 no other concerns identified. All residents with a sudden change in condition have the potential to be affected by this alleged deficient practice. Residents with a change in condition have been reviewed by the DON, ADON, Staff Development Coordinator to ensure that any changes have been identified and appropriate follow up completed.

Activity assistant was educated by the Staff Development Coordinator on 4/22/17 on identifying an emergency situation which included recognizing an emergency situation episode that maybe characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging, calling 911 immediately and staying with the resident.

The facility Administrator, DON, ADON, Unit Managers, Nursing Supervisor, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions Director, Rehab Services Manager, and Medical Records Staff were educated by the Regional Nurse Consultant on 4/22/17 on the policies and procedures regarding life threatening events. 1) Call 911 if initial assessment indicates such action is necessary and 2) Notify MD and facility pending location of life threatening event. The above training was performed face to face in order to facilitate discussion and question on policies, procedures and processes. Department administrative managers can ' t return to work until education is provided.

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F 224	Continued From page 22 Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided. The credible allegation was verified on 4/23/17 at 5:02 PM. The Activity Assistant was interviewed on 4/23/17 at 4:16 PM and was able to describe the education she received. Assessments of the residents who attended the activity, as well as those who had not attended the activity were reviewed. Communication forms (SBAR) were created for every resident that was assessed. The change of condition policy was reviewed and it was noted life threatening events were defined. In-service topics included elder outings and emergency events. Sign-in sheets were reviewed. Random staff in the nursing home including a unit secretary, licensed nurse, nurse aide/activity assistant were interviewed between 4:32 PM and 4:56 PM to confirm they had received in-services. The Staff Development Coordinator was interviewed to confirm there was a system to train all staff prior to reporting to duty. The immediate jeopardy was removed on 4/22/17.	F 224		

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2. Immediate jeopardy began on 4/10/17 at 10:28 PM when Resident #166 exited the building unattended through the front door of the facility. The resident had been identified as having exit-seeking behavior and was wearing a wander guard (a small transmitting device placed on a resident's wrist or ankle, which would trigger an alarm when it comes in close proximity to an exit door). The door alarm sounded, but a staff nurse turned off the alarm from a remote location (the 200 Hall Nursing Station) using a reset button without identifying the reason why the alarm had been activated. Immediate jeopardy was removed on 4/22/17 for F224.

The facility remained out of compliance at a lower scope and severity of D (isolated with no actual harm with the potential for more than minimal harm that is not immediate jeopardy), for the facility to complete staff training and to monitor its corrective action to ensure appropriate procedures are put into place for responding to a door alarm when it is activated.

The findings included:

Resident #166 was in the hospital from 2/23/17 - 3/6/17. The Hospital Discharge Summary of 3/6/17 indicated the resident had a discharge diagnosis of a small right sided mass and large left sided mass along the tentorium (a membranous cover or horizontal partition) with a mild mass effect on the dorsal midbrain (an intracranial or brain mass). He had a secondary diagnoses of seizures.

The resident was discharged from the hospital and admitted to the facility on 3/6/17. His cumulative diagnoses included seizure disorder,

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difficulty in walking, muscle weakness, cognitive communication deficit.

A review of Resident #166's admission Minimum Data Set (MDS) assessment dated 3/13/17 revealed the resident had intact cognitive skills for daily decision making. No wandering behaviors were noted; one fall was reported within the last month prior to admission. The resident required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of being independent for eating.

A review of the resident's Care Area Assessment (CAA) Summary dated 3/14/17 revealed the resident had a history of seizures and altered mental status during his hospitalization. No wandering behaviors were noted.

On 3/29/17, a Situation-Background-Appearance-Review (SBAR) Communication Form indicated the resident had a change in condition. The SBAR noted Resident #166 had a positive urinalysis for a urinary tract infection, with symptoms first noted on 3/25/17. The resident's mental status evaluation reported there was an increase in confusion or disorientation at that time.

On 4/1/17, an Elopement Risk Evaluation was completed. At that time, the resident was determined to be at risk for elopement.

A review of Resident #166's medical record revealed a physician's telephone order was received on 4/1/17 to use a wander guard for the resident, check its placement and function every shift, and monitor the resident's whereabouts throughout the facility every 2 hours.

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Further review of the resident's medical record included an SBAR Communication Form dated 4/2/17 and written by Nurse #4. The SBAR form reported Resident #166 had become combative and was attempting elopement. Nursing notes on the form indicated this change started on 3/30/17 and had gotten worse. The resident's Mental Status Evaluation noted the resident had an increase in confusion or disorientation; memory loss; and other symptoms or signs of delirium. The resident was noted to be uncooperative with staff and care and had tried to exit the facility unassisted in his wheelchair with no shoes on. The Nursing Narrative on the SBAR read as follows:
"Resident became combative this AM (morning) with ADL care and started swinging at staff refusing any assist but was incontinent at the time. Two staff members were able to transfer Resident to wheelchair and get him to the restroom to provide AM care and put clothes on. Once getting into wheelchair resident took his shoes and sock back off and proceeded to front door to leave and redirected back inside facility where he began kicking at staff but able to get him to move away from front door. Resident then went to another exit door and proceeded to go out again and staff tried to redirect him telling him to wait for his family and he said he hadn't seen them in years and he was leaving now to go out. Resident continued to be barefoot at that time and kicked, hit and spit at staff. Resident was transferred back to bed with 3 staff members assist and PRN (as needed) given while staff sat at bedside until medication began to work and resident became quiet and sleepy. Once asleep family informed of events and wander guard placed on resident's leg."

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A review of Resident #166's care plan revealed the care plan had been updated on 4/3/17 to include an area of focus which indicated the resident was at risk for elopement as evidenced by exit seeking behaviors and attributed to cognitive deficits. Interventions listed on the care plan included: Use audible monitoring system to alert staff of exit seeking behavior (dated 4/3/17); Check audible monitoring system for proper functioning per policy (dated 4/3/17); and, 11:00 PM-7:00 AM sitter (not dated).

Further review of the resident's medical record included an Interdisciplinary Note dated 4/10/17 at 2:43 PM, which read: "The resident is being reviewed by IDT (Interdisciplinary) Team for Elopement/Wandering at this time as the resident due to current medical status and cognitive deficits tends to speak of leaving this place now and therefore has the wander guard in place with good results at this time. Continue with wander guard at this time."

A review of Resident #166's medical record included an SBAR Communication Form dated 4/11/17. The SBAR form reported a change in the resident's condition occurred on 4/10/17, noting he had increased agitation, confusion and elopement. The SBAR reported the condition started on 4/10/17; the condition/symptom/sign had occurred before; and the treatment for the last episode was implementation of a wander guard. Resident #166's Mental Status Evaluation reported increased confusion or disorientation; memory loss; and other symptoms or signs of delirium. The Nursing Narrative for the SBAR read as follows:
"Resident noted with increased agitation and

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confusion and even refused hour of sleep care. Resident noted with incoherent speech and was unable to follow directions. Resident scattered his belongings on the floor and then propelled himself out of the room. He apparently eloped through the main entrance. One of the staff members was going to her car at about 10:30 PM when she noted the resident trying to cross [Street Name] on a wheelchair. She brought the resident back to the building and informed this writer of what had transpired. Resident had wander guard to left ankle intact. Wander guard working well. Staff were asked to keep a close eye on the resident. [Name of practitioner service] on call paged and informed of resident's change in status. She gave an order for 0.5 mg (milligrams) Ativan po (by mouth) or IM (intramuscularly) x 1 (one dose). Resident already had Ativan 0.5 mg po ordered. Resident offered the medication and he took it. Resident's family called and notified of the proceedings and said that the companion would be here. The companion never showed up. Family called at 11:10 pm. At 11:15 pm, resident was observed propelling himself along the hallway towards the rehab hall. Resident tried to escape through the rehab hall but was brought back before he could exit the building. He did set off the alarm though. This nurse asked the resident if he was tired and was ready to go to bed. Resident stated he was ready to go to bed. The nurse assisted the resident to bed and he stayed in bed the whole shift. Resident checked on every hour while in bed. Will continue to monitor."

Further review of Resident #166's care plan revealed a hand-written notation on the care plan read: "4/11/17 Resident walked to parking area."

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An interview was conducted on 4/20/17 at 4:15 PM with the Assistant Director of Maintenance. The Director of Maintenance was not available for an interview. The Assistant Director stated all exit doors had a key pad adjacent to the door. If the correct code was entered on the key pad, the door would open without activating the door alarm. If the correct code was not entered on the key pad and the release bar on the exit door was pushed, the door alarm would be activated. If the locked exit door's release bar was pushed for 15 seconds, the door would open. He reported the main entrance door was the only exit with a wander guard protection. If a resident with a wander guard came within 2 feet or so of the door, it would lock down. If the door was already open (as when a visitor goes out), the door would alarm. If a resident with a wander guard pushed on the front exit door for 15 seconds, it would unlock and continue to alarm until a code was entered into the key pad adjacent to the door. The Assistant Director of Maintenance stated the main entrance (front exit door) of the facility was locked at 9:00 PM to 5:00 AM daily. During that period of time, whether or not a resident had a wander guard, the front exit door would alarm when the door release bar was pressed. If the release bar was pressed for 15 seconds, the door would unlock to allow someone to exit. Upon inquiry, the Assistant Director reported there had been no problems with the door alarms during the 5 years he had worked at the facility.

An observation was conducted on 4/20/17 from 4:25 PM through 4:39 PM. Accompanied by the Maintenance Assistant Director, the alarms on all 8 facility doors were tested and observed to be in working order. The main entrance door was tested with use of an activated wander guard.

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The wander guard initiated the door to lock as it was brought close to the doorway. When asked who would be responsible to respond to a door alarm if it was alarming, the Assistant stated, "everyone." He noted this was particularly important at night because there was less staffing on those shifts.

An observation was conducted of Resident #166 on 4/20/17 at 5:00 PM. The resident was lying on his bed resting. He was dressed and well-groomed. The resident was noted to have a wander guard around his ankle.

An interview was conducted on 4/21/17 at 7:38 AM with Nurse #1 who worked the evening of 4/10/17 at the time Resident #166 exited the facility. The nurse stated the resident had anxiety when she first came on the shift and she had asked the Nursing Assistant (NA) to keep an eye on him. At about 9:30-10:00 PM that evening, she recalled going to check on the resident. He was in his room rolling around and pulling on "stuff." At that point, she again told the NA to please keep a close eye on him. The nurse stated she was at the 200 Hall nursing station doing an admission for a new resident when she heard the facility's front door alarm go off. She stated that was around the time the next shift of staff came in and explained that if a staff member coming into the facility put in the code and pushed on the door bar too soon, the alarm would sound. Nurse #1 stated she could turn off the facility's front door alarm from the nursing station, so she did without identifying the cause of the alarm and she continued to do her work. The nurse recalled "less than 30 minutes later," she saw an NA pushing the resident down the hall in his wheelchair. The NA told the nurse he was

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outside and was about to cross the road [Street Name]. She asked the NA if he had a wander guard on and he did. The nurse stated they figured out he had pushed on the door long enough to make it open. The resident was reported as confused at that time and he was set by the nursing station. The nurse observed the resident propel himself down the Rehab hall. He tried to open that door and it alarmed; however, staff reached him before he was able to actually open the exit door. Resident #166 stated he was tired at that point and the nurse assisted him to bed. When asked how often the front door alarm was activated each night after being locked at 9:00 PM; the nurse stated "pretty often." Upon further inquiry, she indicated the alarm was activated more than once a night, and she would have to either reset the alarm from the Nursing Station or enter the code at the door. Upon further inquiry, the nurse reiterated the resident had a wander guard on and the alarm on the door was working. When asked what staff was supposed to do when a door alarm sounded, the nurse stated they were supposed to go and check the door because they need to check on who is going out the facility's door.

An interview was conducted on 4/21/17 at 8:10 AM with the Director of Nursing (DON) upon her request. The DON stated the door alarms could not be deactivated at the Nursing Station. She reported the only way to silence the alarm was by putting in a code at the door itself.

A follow-up interview was conducted on 4/21/17 at 8:15 AM with Nurse #1. Upon request, the nurse pointed out the location of the reset button used to deactivate the facility's front door alarm at the 200 Hall Nursing Station.

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A follow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of Maintenance.
Upon inquiry, the Assistant stated he had heard about the incident when Resident #166 exited the building on 4/10/17. He reported the Maintenance Director had gotten the camera feed for review. The camera surveillance included only video (no audio). When asked, the Assistant Director confirmed that after 9:00 PM (with or without wearing a wander guard), any push on the door bar would sound the alarm. Upon inquiry as to how the alarm would be silenced, he stated someone would need to enter the code at the door. When asked about the reset button located at the 200 Hall Nursing Station used to silence an alarm, the Assistant Director stated, "That would be news to me."

An observation was conducted on 4/21/17 at 9:27 AM. Accompanied by one surveyor, the Maintenance Assistant Director used a wander guard to activate the alarm on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button (identified by Nurse #1) was pushed, the alarm was silenced. However, someone entered the building at that time so it was unclear as to whether or not the alarm was silenced by the guest entry or by pushing the button at the Nursing Station. A second observation was made on 4/21/17 at 9:30 AM. Accompanied by a surveyor, the Assistant Director of Maintenance again used a wander guard to activate the alarm on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button was pushed, the alarm stopped. The Assistant Director of Maintenance

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stated at that time, "She must have cut it off."

On 4/21/17 at 9:32 AM, the Assistant Maintenance Director and Unit Manager #1 were interviewed in regards to the button used to deactivate the door alarm. The Unit Manager stated she had worked at the facility for 4 years and did not know about the button. The Assistant Director of Maintenance stated, "That's not good to have."

On 4/21/17 at 10:45 AM, a telephone interview was conducted with NA #1. NA #1 was identified as the nursing assistant who found the resident outside of the building. The NA reported she worked from 7:00 AM to 11:00 PM on 4/10/17. NA #1 recalled hearing the loud alarm that evening (the sound that occurs past the warning beeps during the first 15 seconds upon activation of the door alarm). She was in the back of the 100 Hall at the time. The NA stated within 1-2 minutes after the alarm sounding, she went to the front door to specifically put in the code and turn off the alarm. She stated she was not going to her car. No one was around the main entrance door, so she went outside to look around. She reported seeing a man in a wheelchair on the sidewalk, just past the Rehab awning facing [Street Name]. The NA stated she discovered it was Resident #166 so she brought him back into the building. When asked how long the resident would have been out of the building (between the time the alarm sounded and when she brought him back in), she stated, "1-2 minutes." Upon inquiry about the longer time frame noted by the facility (based on camera surveillance), the NA stated she, "didn't know about that" and reported she responded to the loud door alarm "in a couple seconds."

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On 4/21/17 at 11:24 AM, a telephone interview was conducted with the Nurse #4. Nurse #4 had worked with the Resident #166 on 1st shift on 4/1/17 and 4/2/17. Nurse #4 recalled Resident #166 had tried to exit from the front door. At that time, he did not have a wander guard. However, there were people in the lobby and he was redirected. He then tried to exit near Rehab and activated the door alarm there. Nurse #4 stated staff were able to stop him from going out the door. However, based on what she had seen, the nurse stated she went ahead and updated the resident's Elopement Evaluation, and also called the family and Nurse Practitioner (NP). The NP reported the resident already had an order for an antianxiety medication to be used as needed for periods of agitation. Use of a wander guard was initiated at that time. When the nurse was asked how she could deactivate the door alarm, she stated, "The only way I know is to go to the door to (enter the code and) deactivate the alarm. That's how we knew he was trying to exit the door."

Accompanied by the Assistant Maintenance Director and the Corporate Nurse Consultant, the camera surveillance video from evening of 4/10/17 was viewed on 4/21/17 at 1:26 PM. The Assistant Maintenance Director reported while the date on the camera surveillance monitor was correct, the time stamp was off and 32 minutes needed to be added to the time stamp to get the correct time from the surveillance. The camera surveillance video from 4/10/17 (with the corrected times) revealed the following:
--At 10:25 PM (corrected time), Resident #166 was observed as he pushed on the front entrance door. Upon viewing this portion of the video, the

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(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
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Assistant Director of Maintenance stated the alarm would have gone off at that time.
--Resident #166 was observed as he sat in his wheelchair in front of the door for 1-2 minutes.
--At 10:27 PM (corrected time), the resident was observed as he proceeded back down the facility hallway.
--At 10:27 PM (corrected time), Resident #166 re-approached the front entrance door.
--At 10:28 PM (corrected time), the resident was observed as he opened the front exit door and went through first door, then the second door to get outside of the facility.
--At 10:32 PM (corrected time), a staff member (identified as NA #1 by the Corporate Nurse Consultant) opened both doors and stood outside of the facility's front entrance door. The NA was observed with a purse over her shoulder, a light jacket tied around her waist, and holding her cell phone. Initially upon exiting the building, the NA was observed to be using and/or viewing a cell phone. She was out of view of the camera for brief periods of time.
--At 10:36 PM (corrected time), an unidentified man came to the front entrance door and entered the building.
--At 10:36 PM (corrected time), NA #1 was observed as she came back in the building, pushing the resident in his wheelchair.

On 4/21/17 at 1:45 PM, the facility's DON joined the Assistant Director of Maintenance as the camera surveillance and timeline from 4/10/17 were being discussed. An interview was conducted with the DON at that time. During the interview, the DON stated she had worked at the facility for 12 years and did not know there was button at the Nursing Station to disarm the door alarm. At that time, the Assistant Director of

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Maintenance was asked in the presence of the DON if the reset button at the 200 Hall Nursing Station worked to silence the alarm. He stated, "Yes it did." When the DON asked him if it actually deactivated the alarm, the Assistant Director of Maintenance confirmed the button did deactivate the alarm when it was tested. Upon inquiry, the DON stated the reset button should "Never, ever" be used. She reported her expectation would be for the staff to immediately investigate why a door alarm was activated.

An observation was made on 4/22/17 at 9:52 AM as NA #1 identified the location of Resident #166 when he was found outside on 4/10/17. At that time, the Assistant Director of Maintenance measured how far the resident was from the front door entrance where he exited the facility, and how far the resident was from the street when he was found. Measurements determined the resident had traveled 108 feet from the front entrance of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility at the time he was found. Measurements revealed Resident #166 was 109 feet from the curb adjacent to the street.

A telephone interview was conducted on 4/22/17 at 11:47 AM with NA #2. NA #2 was the 2nd shift nursing assistant assigned to care for Resident #166 at the time he exited the facility on the evening of 4/10/17. Upon inquiry as to what she recalled about the evening of 4/10/17, the NA reported she knew the resident kept going to the front door of the facility. However, she did not know Resident #166 actually got out of the facility. When asked if the door alarm went off that evening, NA #2 stated, "Yes, that's how we knew he was going to the door." Upon inquiry,

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the NA recalled the door alarm only went off for a few seconds at a time that evening (not minutes).

On 4/21/17 at 4:25 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation. The allegation of compliance indicated:

Credible Allegation F224

On 4/10/17 at 2156 (9:56 PM), Resident #166 was observed outside the facility on the sidewalk near the rehab side of the building. It was determined that the door alarm had sounded as resident #166 exited the facility. Nurse #1 heard the alarm sounding, but did not attempt to identify the cause of the alarm, and silenced the alarm utilizing a reset button at the nurses' station. Nurse #1 was suspended pending investigation on 4/21/2017. A skin assessment was completed for Resident #166 on 4/10/17 with no injury identified. The physician and responsible party was notified [Name of Nurse #1] on 4/10/2017. Resident #166 was placed on every one hour monitoring by the charge nurse.

On 4/5/17 Resident #67 went on outing with activity assistant and two interns, Resident #67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, leaving Resident #67 with interns, intern called 911, emergency personnel arrived, suctioned Resident #67, applied O2 and bagged due to agonal breathing and Resident #67 was transported to the hospital by EMS. Resident #67 chart and care plan was reviewed on 4/21/17 by the Director of Nursing or Signature Care Consultant to ensure resident's quality of care and quality of life were being met, no other concerns identified.

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B. All residents have the potential to be affected by this deficient practice. A head count was completed on 4/11/17 at 12:00 am for the entire facility by the charge nurse to ensure no other residents were affected by the potentially negligent behavior. All residents were accounted for and safe. On 4/11/17, 8 resident wander guards were checked for placement and functioning by the charge nurse and the central supply clerk. All were found to be in place and functioning properly. No other potential areas of neglect were identified.

All residents have the potential to be affected by this deficient practice. Situation with Resident #67 was reviewed with Activity Director on 4/6/17, by the Director of Nursing. Change in condition policy regarding life threatening events was reviewed with the activity assistant on 4/22/17 by the Staff Development Coordinator. Starting on 4/21/2017 Staff Development coordinator, ADON's, Regional Nurse Consultant and Regional team will review policy and procedure regarding life threatening events, to include an episode that may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging and proper emergency protocols with priority of who to call first, call 911 immediately. All residents currently residing in the facility were assessed for any signs and symptoms of distress by the Director of Nursing, Staff Development Coordinator, Charge Nurse and/or the Signature Care Consultant, on 4/22/17, for any possible need for emergency medical assistance. No residents were identified with the need for emergency services.

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C. The Staff Development Coordinator and Social Worker educated the Administrator, DON, ADON, MDS Coordinators, Dietary Manager, Business Office Manager, Payroll Administrative Assistant, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operations Director, Quality of Life Director, and Environmental Services Director starting on 4/11/17 and 4/13/17 regarding the abuse/neglect policy, and responding immediately to door alarms to ensure resident safety. A post-test regarding the abuse/neglect policy was administered to the above stated department managers. Once the facility Administrator, Director of Nursing, Assistant Director of Nursing , Minimum Data Set Coordinators, Staff Development Coordinator, Dietary Manager, Business office manager, Payroll/Administrative Assistant, Social Services Director, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operation, Quality of Life, and Environmental Services were educated and received 100% on the abuse policy and procedure post-test, they were assigned to educate nursing, nursing assistants, dietary, maintenance, housekeeping staff regarding the abuse/neglect policy and procedure, and responding immediately to door alarms to ensure resident safety. All staff will complete a post-test regarding the abuse/neglect policy and procedure education. Staff will not be allowed to work until the education is received and a score of 100% has been obtained on the posttest. If stakeholder did not score 100% on post-test, then stakeholder was immediately re-educated and post-test re-administered. This process continued until all stakeholders obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Regional Nurse Consultant, Regional Team,

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F 224	Continued From page 39 DON, ADON, Staff Development Coordinator or Administrator. The Staff Development Coordinator and Social Worker educated the Administrator, DON, ADON, MDS Coordinators, Dietary Manager, Business Office Manager, Payroll Administrative Assistant, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operations Director, Quality of Life Director, and Environmental Services Director starting on 4/22/17 regarding the abuse/neglect policy, and responding to Life threatening situations. A post-test regarding the abuse/neglect policy was administered to the above stated department managers. Once the facility Administrator, DON, ADON, MDS coordinators, Staff Development Coordinator, Dietary Manager, Business office manager, Payroll/Administrative Assistant, Social Services Director, Central Supply, Marketing/Admissions, Rehab Service Manager, Medical Records, Plant Operation, Quality of Life, and Environmental Services were educated and received 100% on the abuse policy and procedure post-test, they were assigned to educate nursing, nursing assistants, dietary, maintenance, housekeeping staff regarding the abuse/neglect policy and procedure, and responding immediately to life threatening events to include an episode that may be characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging and proper emergency protocols with priority of who to call first, call 911 immediately. All staff will complete a post-test regarding the abuse/neglect policy and procedure education. Staff will not be allowed to work until the education is received and a score of 100% has been obtained on the posttest. If stakeholder did	F 224		

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F 224	Continued From page 40 not score 100% on post-test, then stakeholder was immediately re-educated and post-test re-administered. This process continued until all stakeholders obtained a 100% score on post-test. All post-tests were reviewed for compliance by the Regional Nurse Consultant, Regional Team, DON, ADON, Staff Development Coordinator or Administrator. Facility alleged IJ removal 4/22/2017 The credible allegation was verified on 4/23/17 at 5:02 PM. The Activity Assistant was interviewed on 4/23/17 at 4:16 PM and was able to describe the education she received. Assessments of the residents who attended the activity, as well as those who had not attended the activity were reviewed. Communication forms (SBAR) were created for every resident that was assessed. The neglect and abuse policy was reviewed. In-service topics included neglect definitions and elopement. Sign-in sheets and post education tests were reviewed. Random staff in the nursing home including a unit secretary, licensed nurse, nurse aide/activity assistant were interviewed between 4:32 PM and 4:56 PM to confirm they had received in-services. The Staff Development Coordinator was interviewed to confirm there was a system to train all staff prior to reporting to duty. The immediate jeopardy was removed on 4/22/17.	F 224		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and	F 241		5/31/17

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F 241	Continued From page 41 promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to respond to a resident's request for toileting, which compromised the dignity for 1 of 8 resident's reviewed for Activities of Daily Living (resident #97). Findings Included: Resident #97 was admitted on 7/8/16 with the current diagnoses of heart failure, diabetes and hypertension. The resident's Minimum Data Set (MDS) dated 3/3/17 revealed she was moderately cognitively impaired. The resident required extensive assistance with bed mobility, transfers, locomotion, dressing, eating, toilet use and personal hygiene. The resident got intermittent catheterization. She had urinary continence and was frequently incontinent of bowel. The resident had care plans last updated 3/8/17 for Activities of Daily Living and refusal of care. On observation and interview with Resident #97 was completed on 4/20/17 at 10:17 PM. The resident was sitting in her wheelchair in her room. The resident stated that she had been waiting to use the bedpan for an hour. She stated she asked staff before 9:00 PM to get her to the bathroom and bed but was still waiting. She stated she normally used the bedpan or bathroom. On observation, the resident's face was red and the resident's eyes were puffy with tears forming. The resident was moving around in	F 241	F241: A. Resident #97 was placed on the bed pan on 4/20/17 at 10:45pm. The resident urinated, was cleaned, changed into her pajamas and repositioned in bed. B. All residents have the potential to be affected by the alleged deficient practice. An interview was completed with residents with a BIMS (Brief Interview for Mental Status) Assessment score of 8 or above by the Social Services Director, Administrator, or Chaplain, Director of Nursing, Assistant Director of Nursing, on regarding receiving assistance for toileting in a timely manner this was completed by 5/19/17. Corrective actions to be taken for any issues identified with receiving toileting in a timely manner. C. Education was completed for Nursing Staff by Staff Development Coordinator, Director Nursing, Assistant Director of Nursing, Unit Coordinator or Regional Nurse by 5/31/17 regarding the provision of toileting in a timely manner to maintain dignity for residents. D. The Social Services Director, Administrator, Chaplain, Director of Nursing, Assistant Director of Nursing, Central Supply, Medical Records, Business Office Manager, Assistant Business Office Manager, Admissions Coordinator or Rehabilitation Service Manager will complete interviews of 5 residents daily 5 days per week x 4 week, 3 days per week x 4 weeks and once weekly x 4 weeks with a BIMS score of 8	

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her wheelchair as if she was uncomfortable. The resident still had her day clothes on.

On 4/20/17 at 10:28 PM, the resident was still waiting in the wheelchair in her room for staff assistance.

On 4/20/17 at 10:45 PM, the resident was transferred from the wheelchair to her bed with the assistance of NA #6 and NA #9 via the lift. When NA #9 went to get the bedpan out of the bathroom the resident started to yell, "hurry, hurry, I have to go." The resident was placed on the bedpan and urinated. The resident was cleaned, changed into her pajamas and repositioned in bed.

NA #6 was interviewed on 4/20/17 at 11:12 PM. She stated Resident #97 sometimes used the toilet but mostly used the bedpan. She stated the resident always needed assistance from 2 people with the lift and she was rarely incontinent. She stated she always had to find someone to help her with the resident. She stated that at 8:30 PM that evening, the resident told her she wanted to get to bed and she told the resident it was going to be a while because she had other people to see and a new admit and then would get back to her. She stated the resident always used the bedpan before getting to the bed.

Nursing Assistant #8 was interviewed on 4/20/17 at 11:12 PM. She stated the administration was putting extra people on the schedule that were not actually here.

The resident's family member was interviewed on 4/22/17 at 12:41 PM. The resident's family member stated that the resident told him that she

or above to ensure they receive toileting assistance in a timely manner to preserve their dignity. Findings of the above stated interviews will be discussed by the Social Services Director with the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months, for recommendations and further follow up as indicated.

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F 241	Continued From page 43 had to wait an hour sometimes for them to answer the call bell. He stated the resident had told him that it happened again on the evening of 4/21/17 and she had to wait a long time to use the bed pan and then had to wait a long time for the staff to take her off the bed pan. He stated the resident had an accident in the past because the staff could not get her the bedpan in time. Resident #97 was interviewed again on 4/22/17 at 12:41 PM. She stated that she had to wait last night on 4/21/17. On Thursday night, 4/20/17, she had used her call bell to call before 9:00 PM and that the staff never came to assist her. She stated the staff were ignoring her and that made her feel mad. The administrator was interviewed on 4/22/17 at 6:22 PM. He stated that he would expect staff to take care of the residents' needs in a timely manner.	F 241		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		5/31/17

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F 278	Continued From page 44 that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code the minimum data set (MDS) to accurately reflect the residents condition for 2 of 2 residents that were reviewed for urinary catheters (Resident #117 and Resident #111), 1 of 6 residents reviewed for accidents (Resident #4) of 1 resident reviewed for Hospice (Resident #221) and 1 of 1 resident reviewed for Preadmission Screening Resident Review (PASRR) (Resident #49). Findings included: 1.a. Resident # 117 was admitted on 3/3/16 with the diagnoses of muscle weakness, diabetes and urinary retention. The resident had a care plan in place created 8/25/16 for an indwelling urinary catheter.	F 278	F278: A. The Minimum Data Set Coordinator (MDS Coordinator)) completed a modification to the MDS assessment for resident #117 related to the use of an indwelling catheter on 4/22/17. A modification to the MDS assessment was completed by the MDS Coordinator for Resident #221 to remove the check mark that indicated the resident was on a physician prescribed weight loss regimen on 4/20/17. A modification to the MDS assessment was completed by the MDS Coordinator on 4/20/17 to identify the fall that occurred on 3/28/17 for Resident #4. A modification was completed to Resident #111 s MDS assessment on 4/22/17 by the MDS Coordinator to identify the use of	

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F 278	Continued From page 45 A physician's note dated 2/23/17 stated that the resident had a chronic urinary catheter. Physician's orders dated 3/13/17 revealed the resident had orders for urinary catheter care every shift and for the urinary catheter bag to be changed once a month. Resident #117 Quarterly Minimal Data Set (MDS) dated 4/3/17 revealed the resident was moderately cognitively impaired. Urinary incontinence was not rated and indwelling catheter was not checked on the MDS assessment. The resident was observed on 4/22/17 at 2:43 PM. The resident had an indwelling urinary catheter in place. The MDS nurse was interviewed on 4/22/17 at 4:30 PM. She stated the resident had an indwelling urinary catheter. She stated that she didn't code the indwelling urinary catheter on the MDS in error. She stated she would make a correction to the MDS. The Administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated he would expect that the MDS was correct and coded to the resident's condition. 2. Resident #221 was admitted on 12/6/16 with diagnoses of hypertension and a past cerebral vascular accident. A nutrition note dated 2/23/17 stated the resident had weight loss and was 98 pounds. The resident was on a regular diet with fortified foods and supplements.	F 278	an indwelling catheter. A modification was completed to the MDS assessment by the MDS Coordinator on 4/22/17 for Resident #49 to correctly code the PASRR level 2 status. B. All residents have the potential to be affected by the alleged deficient practice. The MDS Coordinator and the Regional MDS Consultant completed a review of MDS assessments by 5/17/17 for residents requiring the use of indwelling catheters, residents with weight loss for the last 6 months, residents who have experienced a fall in the last 6 months, and residents who have a PASRR Level 2 status to ensure they were coded correctly on the most recent comprehensive MDS assessment. Corrective actions were completed as indicated by the MDS Coordinator. C. Education was provided to the MDS Coordinator on 4/24/17 by the Regional MDS Consultant regarding the importance of correct coding of MDS assessments. D. The Regional MDS Consultant or Director of Nursing will complete an audit of 10 Resident□s MDS assessments monthly for 3 months to ensure accurate coding. The MDS Coordinator will present findings of the above stated audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly for 3 months for recommendations and further follow-up as indicated.	

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Resident #221's Significant change MDS dated 3/17/17 revealed the resident had a 5% or more of weight loss in the last month, or loss of 10% or more weight loss in the last 6 months and was on a physician prescribed weight loss regimen. The resident had a care plan last updated on 3/21/17 for nutritional decline and hospice care.

The MDS nurse was interviewed on 4/20/17 at 2:57 PM. She stated the resident was put on hospice and had a decline so a significant change MDS was completed. The dietitian coded section K of the MDS. The resident was not on a physician prescribed weight loss regimen. However, the resident did have a significant weight loss. The MDS nurse stated she did not code section K. She stated she only signed the end of the MDS stating that her section was completed and accurate. She stated the resident should have been coded as having a 5% weight loss and that she was not on a physician prescribed weight loss regimen. She also stated that section K was never signed by whomever coded that section of the MDS.

The Registered Dietitian was interviewed on 4/22/17 at 10:23 AM. She stated she did not code this resident's section K significant change MDS. She stated that she would not code a section of the MDS and not sign the last page of the MDS. However, there was always the potential for a data entry error. She did not think she coded that section but typically would code section K of the MDS and update the Care Area Assessment.

The Administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated he would expect that the MDS was correct and coded to the resident's condition.

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3. Resident #4 was originally admitted to the facility on 5/12/2014 with cumulative diagnoses which included diabetes and seizure disorder.

Medical record review revealed Resident #4 experienced a fall to the floor on 3/28/17.

Review of the quarterly Minimum Data Set (MDS) assessment dated 4/13/17 revealed the MDS was coded as no falls occurred under Section (J) for Falls History since the last quarterly MDS assessment completed on 1/24/17.

Interview on 04/20/2017 at 3:12 PM with the MDS nurse revealed the incorrect code on the MDS was an oversight.

Interview on 04/22/2017 at 4:24 PM with the administrator revealed his expectation was the MDS be accurate.

4) Resident #111 was admitted to the facility on 4/6/17 and her diagnoses included retention of urine.

A review of the April 2017 physician orders for Resident #111 revealed orders to provide urinary catheter care every shift, change urinary catheter bag monthly, secure urinary catheter with leg strap at all times and change urinary catheter as needed.

A review of the admission MDS, dated 4/6/17, for Resident #111 revealed that her urinary catheter was not coded on the MDS.

A review of the care plan dated 4/6/17 for Resident #111 revealed she had a risk for

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F 278	Continued From page 48 complications related to indwelling catheter for bladder elimination. An observation of Resident #111 on 4/22/17 at 9:20 am revealed she had an indwelling urinary catheter. An interview with the MDS nurse on 4/22/17 at 9:38 am revealed that Resident #111 had a urinary catheter. She stated she missed coding the catheter as an appliance on her admission comprehensive assessment dated 4/6/17. 5) Resident #49 was admitted to the facility on 11/7/15 and her diagnoses included depression and end stage renal disease. A review of the PASRR determination notification form dated 9/22/14 revealed that Resident #49 was determined to be a PASRR level 2. No expiration date was identified. A review of the annual comprehensive MDS dated 10/7/16 for Resident #49 revealed that the MDS was not coded for PASRR level 2. An interview with the Social Services Director on 4/22/17 at 8:47 am revealed that Resident #49 had been a PASRR level 2 since she was admitted to the facility. An interview with the MDS nurse on 4/22/17 at 9:34 am revealed that the annual MDS dated 10/7/16 for Resident #49 had not been coded correctly for PASRR level 2.	F 278		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		5/31/17

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F 309	Continued From page 49 483.24 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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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: Based on record review, staff and paramedic interviews the facility staff left a resident in distress, unattended and failed to initiate	F 309	F309: A. On 4/5/17 Resident # 67 went on outing with activity assistant and two	

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F 309	Continued From page 50 emergency medical services for a resident gasping for air (Resident #67). Immediate jeopardy began on 4/5/17 when Resident #67 was out of the facility on an activity outing to a local ice cream shop, was gasping for air after eating an ice cream cone, and nursing home staff left the resident unattended and did not initiate emergency medical services immediately. The immediate jeopardy was removed on 4/22/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings Included: Resident #67 was admitted to the facility on 9/12/12 and her diagnoses included spasmodic torticollis (a chronic neurological movement disorder causing the neck to involuntarily turn to the left, right, upwards, and/or downwards), dysphagia and postural abnormalities. A quarterly minimum data set (MDS) dated 2/10/17 for Resident #67 revealed her cognition was intact and she required supervision and one person physical assist with eating. A care plan dated 1/24/17 revealed Resident #67 was active and at risk for behavior problems as evidenced by refusal to follow Medical Doctor (MD)/Nurse Practitioner (NP) orders related to dysphagia due to neuralgia. Resident #67 refused diet texture downgrade and a swallow study. The goal was that Resident #67 would have fewer	F 309	interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, leaving Resident # 67 with two activity interns, one intern called 911. Emergency Medical Service (EMS) arrived, suctioned Resident # 67, applied oxygen and bagged resident, and transported Resident # 67 to Hospital. Resident was admitted to hospital. B. All residents on the outing were assessed for any change in condition by the Director of Nursing (DON), Assistant Director of Nursing (ADON), on 4/5/17 no other concerns identified. All residents with a sudden change in condition have the potential to be affected by this alleged deficient practice. Residents with a change in condition have been reviewed by the DON, ADON, Staff Development Coordinator to ensure that any changes have been identified and appropriate follow up completed. Activity assistant was educated by the Staff Development Coordinator on 4/22/17 on identifying an emergency situation which included recognizing an emergency situation episode that maybe characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging, calling 911 immediately and staying with the resident. C. The facility Administrator, DON, ADON, Unit Managers, Nursing Supervisor, Minimum Data Set Coordinator (MDS), Staff Development Coordinator (SDC),	

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F 309	Continued From page 51 episodes of choking/aspiration as evidenced by behavior occurring less than weekly. Interventions included report to physician changes in behavioral status. Anticipate care needs and provide for the resident. Refer to Registered Dietitian (RD) and Speech Therapist (ST) as needed. An entry in the nursing notes dated 1/27/17 revealed Resident #67 had an episode of choking while taking her medications which were crushed in vanilla pudding. Code blue was called and cardiopulmonary resuscitation (CPR) was initiated. She was able to start breathing normally again. An order was received to obtain a chest x-ray which came back negative for aspiration. A telephone interview on 4/21/17 at 9:45 am with the ST that treated Resident #67 revealed she had last treated her in late January for about a week. She stated that Resident #67 had a history of choking. An entry in the nursing notes on 4/5/17 revealed Resident #67 was sent by ambulance to University of North Carolina (UNC) hospital from an activity outing at an ice cream shop due to potential aspiration. A review of the emergency medical services (EMS) patient care report dated 4/5/17 for Resident #67 revealed that they arrived at local ice cream shop at 2:45 pm. The report stated that EMS was dispatched for cardiac arrest. The Fire Rescue (FR) arrived on scene prior to ambulance and obtained history of the event from bystanders (the facility Activity Assistant and intern volunteer). Patient (Resident #67) had just gotten ice cream	F 309	Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions Director, Rehab Services Manager (RSM), and Medical Records Staff were educated by the Regional Nurse Consultant on 4/22/17 on the policies and procedures regarding life threatening events. 1) Call 911 if initial assessment indicates such action is necessary and 2) Notify physician and facility pending location of life threatening event. The above training was performed face to face in order to facilitate discussion and question on policies, procedures and processes. Department administrative managers can□t return to work until education is provided. Once the facility Administrator, DON, ADON, Unit Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and Housekeeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided.	

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F 309	Continued From page 52 with a group from her care facility when her bystanders stated she became apneic (temporary suspension of breathing) and unresponsive. Cardiopulmonary resuscitation (CPR) was initiated by bystanders at that time. FR arrived at the scene and found the patient breathing but responsive only to painful stimuli and discontinued CPR. At that time FR placed resident on 10 liters of oxygen and status post oxygen saturation level was 90%. Patients baseline level of responsiveness was not known, but "better than this" per bystanders. Per FR bystanders knew very little about resident. Assessment of patient by Paramedic revealed upon arrival patient was sitting in her wheelchair. She was non-verbal and responsive to painful stimuli. Her breathing was shallow and abnormally slow with a respiration rate (RR) of 8 per minute. She had strong radial pulses present and her skin appeared pale and waxy. Treatments administered to patient were documented as placement on 10 liters of oxygen, respirations assisted via bag valve mask, administration of 5 milligrams (mg) of albuterol, intravenous administration of 300 cubic centimeters (cc) of normal saline and transport to the hospital emergency department. A phone interview was conducted with Paramedic #1 on 4/26/17 at 10:40 am. She confirmed that she had responded to the call on 4/5/17 at the ice cream parlor for Resident #67. She stated that when she arrived on the scene Resident #67 was sitting in her wheelchair and was minimally responsive. She stated that Resident #67 looked very bad. She stated that she had been started on oxygen and intravenous fluids. She stated that Resident #67 required manual help with respirations and that was conducted during the	F 309	D. A Quality Assurance (QA) meeting will be held weekly beginning on 5/4/17, then weekly for 4 weeks, then monthly times 2 months for recommendations and further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing and ensure quality of care and quality of life is being delivered as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of Regional Staff weekly times 4 weeks, then monthly times 2.	

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ambulance trip to the hospital. She stated that she did not observe the resident receiving CPR and that it was not indicated because Resident #67 was breathing, not well, but was breathing and did not require CPR. She stated that she did not observe that the resident was choking and did not perform any suctioning or treatment for that. She stated that she was concerned that the facility staff members that were with Resident #67 did not seem to know anything about her health condition and they were trying to get someone from the facility to bring her medical records. She stated that it was 5 to 10 minutes before anyone from the facility arrived with her medical records.

A review of the hospital admission records dated 4/5/17 for Resident #67 revealed she presented unresponsive in the emergency room. It stated that Resident #67 was at an ice cream parlor on 4/5/17 with her friends from her facility when she suddenly became unresponsive. She received bystander CRP - unknown if she ever lost a pulse. When EMS arrived, she had a RR of 5 and was bagged for 3-4 minutes.

A review of the hospital discharge summary dated 4/8/17 for Resident #67 revealed a diagnosis of septic shock secondary to a urinary tract infection (UTI).

An interview on 4/20/17 at 10:30 am with the Activity Director revealed that she was not working at the facility on 4/5/17. She stated that when she returned to work on 4/6/17 she learned that the Activity Assistant and 2 volunteers had taken Resident #67 on an outing to the ice cream shop on 4/5/17. She stated that they had written statements of the incident and the statements were provided to the Director of Nursing (DON).

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She stated that typically when residents are taken out of the facility for an activity she would provide a list of residents that were going to the DON. She stated that a nurse or nursing assistant (NA) did not always accompany them on the outings and that it depended on the type of outing they were going on.

A review of the "Off-Premise Activities" policy dated August, 2007; revision date January 2009 provided by the Activity Director on 4/20/17 revealed procedure #3 stated "At least one or more members of nursing services will accompany the activity director / coordinator on field trips."

An interview on 4/20/17 at 10:45 am with the Assistant Activity Director revealed she had been on the outing with Resident # 67 on 4/5/17. She stated that she had come in to work at 1:00 pm on 4/5/17 and decided to take a few residents to the ice cream shop. She was accompanied by 2 volunteer interns that were recreational therapy students at a local college. She stated that Resident #67 ordered butter pecan ice cream in a waffle cone and they all sat outside to eat their ice cream. She stated Resident #67 did not appear to have any trouble eating her ice cream cone. When they finished they started to walk back to the facility as it was national walking day (Resident #67 and the other 2 residents were in wheelchairs and the activity assistant and 2 volunteers were pushing them). She stated that Resident #67 started to gasp for air and she asked her if she needed something to drink and Resident #67 nodded yes. The Activities Assistant went to a drugstore to get her a bottle of water which took approximately 5 minutes. She stated when she came out of the store Resident #67

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was opening her mouth, gasping for air, was not able to speak and seemed to be less responsive. She stated the intern volunteer was calling 911 and the 911 operator asked for medical information about Resident #67. She called the facility to try and get the information. She stated the 911 operator told them to try and get her laying down and they were able to lay her wheelchair back. She stated EMS arrived and they placed a tube down her throat and sucked out a piece of waffle cone. A nursing assistant from the facility arrived about 5 to 10 minutes after she had called the facility and then a nurse from red hall came (didn ' t know her name). She stated that Resident #67 seemed fine all day. She stated that she had not let Resident #67 ' s nurse know that she was taking her out. She stated that she did not have any training in emergency health procedures.

An interview on 4/20/17 at 1:30 pm with Nurse #3 revealed she was the nurse for Resident #67 on 4/5/17. She stated that the resident had been fine all day. She stated that she went to find her to provide her afternoon medications and found out that activities had taken her out to get ice cream. She stated that they didn ' t even tell her that they were taking her out. She stated that "everyone "(did not elaborate on who "everyone" was) knew that Resident #67 had trouble swallowing and had choked once or twice in the past.

An interview with the DON on 4/20/17 at 4:20 pm revealed that she was not in the facility on 4/5/17 and was not aware of the details of what happened with Resident #67 that day. She referred me to the Unit Manager #1.

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An interview with Unit Manager #1 on 4/20/17 at 4:32 pm revealed that she was returning to the facility from her lunch break on 4/5/17 and a facility staff member (could not remember who) stopped her and told her that Resident #67 was unresponsive down the street at the ice cream shop. She stated she obtained Resident #67 ' s medical information and brought it to the EMS staff. She stated Resident # 67 had already been put in the ambulance by that time. She provided the medical information, including that she was a full code, to EMS. She stated that she was not aware of any further interventions or follow-up by the facility after the incident.

An interview on 4/21/17 at 1:00 pm with the activities intern / volunteer revealed that she had accompanied Resident #67 on the outing to the ice cream shop. She stated that everyone had finished their ice cream and they were walking the residents back to the facility when Resident #67 started gasping for air. She stated that the Activity Assistant went to get Resident #67 something to drink. While she was gone Resident #67 seemed to be getting worse and she called 911. She stated the resident did not stop breathing. She stated that she had been volunteering at the facility since January 2017 and that she did attend the facility general orientation. She stated that she did not receive any training at the facility on emergency medical response.
A follow-up interview on 4/21/17 at 2:30 pm with the Assistant Activity Director revealed that she had not received any training on the Heimlich maneuver or any emergency medical training.

A review of the statements dated 4/5/17 written by the Activity Assistant and the activities intern

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volunteers provided by the DON confirmed the events as obtained in their interviews.

An interview on 4/21/17 at 2:00 pm with the Staff Development Coordinator revealed that the activity staff are not trained in the Heimlich technique or how to respond in medical emergencies because they don ' t work in a clinical capacity. She stated that volunteers do attend the facility general orientation, but this does not include any medical emergency training such as the Heimlich maneuverer.

An interview on 4/21/17 at 3:45 pm with the Administrator revealed that he was somewhat aware of the incident that occurred on 4/5/17 involving Resident #67. He stated that they had discussed Resident #67 ' s swallowing difficulty the next day in the morning meeting. He stated that this was an isolated incident and that no additional investigation was completed.

On 4/21/17 at 4:25 pm, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 4/23/17 at 2:00 pm. The allegation of compliance indicated:

On 4/5/17 Resident # 67 went on outing with activity assistant and two interns, resident # 67 began gasping for air, activity assistant went to obtain water approximately 100 feet away, leaving Resident # 67 with two activity interns, one intern called 911. EMS arrived, suctioned Resident # 67, applied O2 and bagged resident, and transported Resident # 67 to Hospital. Resident was admitted to hospital.

All residents on the outing were assessed for any change in condition by the DON, ADON, on

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(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 58	F 309		

4/5/17 no other concerns identified. All residents with a sudden change in condition have the potential to be affected by this alleged deficient practice. Residents with a change in condition have been reviewed by the DON, ADON, Staff Development Coordinator to ensure that any changes have been identified and appropriate follow up completed.

Activity assistant was educated by the Staff Development Coordinator on 4/22/17 on identifying an emergency situation which included recognizing an emergency situation episode that maybe characterized by apnea, difficulty breathing, respiratory distress, color change, change in muscle tone, choking or gagging, calling 911 immediately and staying with the resident.

The facility Administrator, DON, ADON, Unit Managers, Nursing Supervisor, MDS Coordinator, Staff Development Coordinator, Director of Dining Services, Business Office Manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions Director, Rehab Services Manager, and Medical Records Staff were educated by the Regional Nurse Consultant on 4/22/17 on the policies and procedures regarding life threatening events. 1) Call 911 if initial assessment indicates such action is necessary and 2) Notify MD and facility pending location of life threatening event. The above training was performed face to face in order to facilitate discussion and question on policies, procedures and processes. Department administrative managers can ' t return to work until education is provided.

Once the facility Administrator, DON, ADON, Unit

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F 309	Continued From page 59 Mangers, Nursing Supervisors, MDS coordinator, SDC, Director of Dining Services, Business office manager, Social Services Director, Central Supply, Chaplain, Marketing/Admissions, RSM, and medical records were educated on the above policies and procedures and processes they were then assigned to re-educate, Nursing staff, nursing assistants, Dietary Staff, Activities, Maintenance and House Keeping staff which started on 4/22/17. No employee will be allowed to work until education is provided. This education will be included in the orientation process for all newly hired staff members. No newly hired employee will be allowed to work until education is provided. The credible allegation was verified on 4/23/17 at 5:02 PM. The Activity Assistant was interviewed on 4/23/17 at 4:16 PM and was able to describe the education she received. Assessments of the residents who attended the activity, as well as those who had not attended the activity were reviewed. Communication forms (SBAR) were created for every resident that was assessed. The change of condition policy was reviewed and it was noted life threatening events were defined. In-service topics included elder outings and emergency events. Sign-in sheets were reviewed. Random staff in the nursing home including a unit secretary, licensed nurse, nurse aide/activity assistant were interviewed between 4:32 PM and 4:56 PM to confirm they had received in-services. The Staff Development Coordinator was interviewed to confirm there was a system to train all staff prior to reporting to duty. The immediate jeopardy was removed on 4/22/17 .	F 309		

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F 312	Continued From page 60	F 312		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interviews, the facility failed to provide a shower, transfer from wheelchair to bed, and toileting assistance to 2 of 8 residents reviewed for activities of daily living (ADL) (Resident #36, Resident #97). Findings included: 1.)Resident #36 was admitted to the facility 2/19/12 and had the following diagnoses of spinal stenosis, anemia and hypertension. The resident had a care plan in place last updated 3/12/17 for ADLs self-care deficit. The goal stated the resident would participate with care and be clean, groomed and dressed by the Resident's choice through next review. Interventions included that staff provide assistance/supervision to meet resident's needs for all ADLs. Resident #36's Minimum Data Set (MDS) dated 3/30/17 revealed the resident was moderately cognitively impaired. The resident was assessed as being totally dependent on staff assistance for bathing. The MDS specified the resident was frequently incontinent of bowel and bladder. Review of Resident #36's shower schedule	F 312	F312: A. The Director of Nursing completed interviews for resident #24 and #36 on 5/19/17, regarding the alleged deficient practice of providing care needs including showers and toileting needs being met and addressed appropriately. Resident #97 no longer resides in the facility. B. Residents with Brief Interview Mental Status (BIMS) 8 or > were interviewed by the Social Services Director, Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Coordinator, Administrator, MDS Coordinator, Staff Development Coordinator, Dietary Manager, Business Office Manager, Central Supply, Admissions Director, Rehabilitation Service Manager and Chaplain to assure their care needs (toileting and showers) are being met. This was completed by 5/19/17). Any concerns identified were addressed. All residents with BIMs of 7 or < were assessed to assure that their care needs are being met as outlined per the residents care plan by the Director of Nursing, Assistant Director of Nursing, Unit Coordinator, or Signature Care Consultant. Any findings were forwarded to the DON to ensure corrective actions	5/31/17

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F 312	Continued From page 61 revealed the resident's shower days were Wednesday and Saturdays. Review of the resident's Activities of Daily Living flow sheet and the shower assignment sheets revealed the resident did not receive a shower or any kind of bath on Saturday 4/15/17. There were no notes in the resident's medical record that revealed the resident got a shower or bath of any kind on Saturday 4/15/17. Nursing Assistant (NA) #5 was interviewed on 4/22/17 at 12:02 AM. She stated that they were really short staffed on Saturday 4/15/17 and she worked first shift. She stated that none of the residents were given a shower on Saturday on Resident #36's hall. She had teamed up with the other NAs to get bed baths done with all other residents because there wasn't enough staff. She stated she worked 16 hours that day. The resident was interviewed on 4/22/17 at 1:49 PM. He stated he really wanted a shower last Saturday, 4/15/17. The resident stated it didn't happen because there was not enough staff. Nurse #5 was interviewed on 4/22/17 at 11:36 AM. She stated that she worked last Saturday 4/15/17 and Sunday 4/16/17 and the Nursing Assistants were short staffed. She stated the nursing assistants got to everyone to provide care the best they could. She stated that she suspected that some showers were missed, but was not told of any that did not get completed. She stated they were really short staffed on the blue hall and the on call nurse never came in. The administrator was interviewed on 4/22/17 at 6:22 PM. He stated that he would expect for staff for take care of the residents' needs.	F 312	are completed. C. Nursing staff (Licensed Nurses and Certified Nursing Assistants) will be in serviced and re-educated regarding Activities of Daily Living care and correct documentation. Education will be completed by 5/31/17 by the Staff Development Coordinator (SDC), Director of Nursing, or Regional Nurse Consultant to address the importance of and policy expectations of meeting residents care needs to include bathing/showers, incontinent care and any other reasonable care needs the resident may have. Secondly, the Administrator, DON, ADON, Unit Coordinator, Licensed Nurse will review daily staffing sheet to ensure sufficient staffing is scheduled to meet the care needs of each resident. D. Care delivery audits will be completed for bathing/showers, and incontinent care; audits will be conducted 5 per day x 4 weeks, 3 per day x 4 weeks, then once weekly x 4 weeks. Any deficit in care delivery will be reported to DON, ADON or Regional Nurse Consultant and reeducation provided to assure understanding and importance of providing good quality care in a timely manner. Results of audits or trends identified will be addressed by the Quality Assurance Committee (QAPI) committee for 3 months as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, Minimum Data Coordinator (MDS),	

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F 312	Continued From page 62 2.) Resident #97 was admitted on 7/8/16 with the current diagnoses of heart failure, diabetes and hypertension. The resident's MDS dated 3/3/17 revealed she was moderately cognitively intact. The resident required extensive assistance with bed mobility, transfers, locomotion, dressing, eating, toilet use and personal hygiene. She had urinary continence and was frequently incontinent of bowel. The resident had care plans last updated 3/8/17 for Activities of Daily Living. Interventions included that the resident required extensive assistance of 2 person with toilet use, bed mobility, and total dependence for transfers. Resident #97 was sitting in her wheel chair in her room on 4/20/17 at 10:17 PM. The resident stated that she had been waiting to use the bedpan and had been waiting an hour. She stated she asked staff before 9:00 PM to get her to the bathroom and bed but was still waiting. She stated she always used the bedpan or bathroom. The resident appeared to be holding back from crying and was moving around in her wheelchair as if she was uncomfortable. The resident still had her day clothes on. On 4/20/17 at 10:28 PM, the resident was still waiting in the wheelchair in her room for staff. On 4/20/17 at 10:45 PM, the resident was transferred from the wheelchair to her bed with the assistance of 2 staff members via mechanical lift. When the nursing assistant (NA) went to get the bedpan out of the bathroom the resident started to scream "hurry, hurry, I have to go". The resident was placed on the bedpan and urinated.	F 312	Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Service Director.	

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F 312	Continued From page 63	F 312		

The resident was cleaned, changed into her pajamas and repositioned in bed.

NA #6 was interviewed on 4/20/17 at 11:12 PM. She stated the resident always needed assistance from 2 people with the lift for transfers from chair to bed and she was rarely incontinent. She stated she always had to find someone to help her with the resident. She stated that tonight at 8:30 PM, the resident told her she wanted to get to bed and she told the resident it was going to be a while because she had other people to see and would get back to her. She stated the resident always the bedpan before getting to the bed.

Resident #24's family member was interviewed on 4/22/17 at 12:41 PM. The resident's family member stated that the resident told him that she had to wait an hour sometimes for them to answer the call bell. He stated the resident had told him that it happened again last night and she had to wait a long time to use the bed pan and then had to wait a long time for the staff to take her off of the bed pan. He stated he knew they were under-staffed and the resident has had an accident in the past because they could not get her the bedpan in time.

The resident was interviewed again on 4/22/17 at 12:41 PM. She stated that she had to wait last night and on 4/21/17 too. She added on Thursday night, 4/20/17, she had used her call bell to call before 9:00 PM and that the staff never came. She stated the staff were ignoring her and that made her feel mad.

The administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated that he would

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F 312	Continued From page 64 expect staff to take care of the residents' needs.	F 312		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to identify the cause of the front door alarm being activated and failed to intervene as a resident with exit-seeking behavior exited the building for 1 of 1 sampled resident (Resident #166) identified to be at risk for elopement. The facility failed to	F 323	F323: A. Resident # 166 was noted by staff to be outside on the sidewalk by the rehab side of the building on 4/10/2017. Resident # 166 was assisted back to the facility by the Certified Nursing Assistant on 4/10/2017 at approximately 10:04 PM.	5/31/17

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F 323	Continued From page 65 maintain the receptacle for extinguishing cigarettes free of potentially flammable items in the designated resident smoking area. This had the potential to impact 6 of 6 residents that were currently identified as smokers. 1. Immediate jeopardy began on 4/10/17 at 10:28 PM when Resident #166 exited the building unattended through the front door of the facility. The resident had been identified as having exit-seeking behavior and was wearing a wander guard (a small transmitting device placed on a resident's wrist or ankle, which would trigger an alarm when it comes in close proximity to an exit door). The door alarm sounded when Resident #166 pushed on the facility's front door, but a staff nurse turned off the alarm from a remote location (the 200 Hall Nursing Station) using a reset button without identifying the reason why the alarm had been activated and without intervening to protect the resident. A credible allegation of correction was accepted. Immediate jeopardy was removed on 4/22/17 at 7:23 PM for F323. The facility remains out of compliance at a lower scope and severity of E (pattern with no actual harm with the potential for more than minimal harm that is not immediate jeopardy), for the facility to complete staff training and to monitor its corrective action to ensure appropriate interventions are put into place for residents at risk for elopement and procedures for responding to a door alarm when it is activated. The facility remains out of compliance to complete corrective actions regarding the maintainence of the receptacle for extinguishing cigarettes in the smoking area.	F 323	and placed at the nurses station for closer monitoring at approximately 10:05 PM. The Charge Nurse assisted the resident to bed. The Charge Nurse changed the bed linens and provided incontinent care for the resident. The nurse performed an assessment on resident #166 during care, no new injuries were noted at this time. The Resident s responsible party and physician were notified of incident by the charge nurse on 4/10/17. Resident #166 was monitored every hour for the rest of the night by the charge nurse. A review of the resident smoking area was completed by the Administrator and Maintenance Supervisor on 5/19/17. The receptacle for cigarette butts was replaced with a red can that appropriately opens and closes. A larger sign was placed on the receptacle to specify that it was to be utilized only for cigarette butts. Another trash can was placed in the resident smoking area by the Maintenance Director on 5/19/17. The fire blanket was removed, cleaned, and replaced by the Maintenance Director on 5/19/17. B. A head count of the entire facility was conducted on 4/11/2017 at 12:00 midnight by the charge nurses. All residents were accounted for and were safe. On 4/11/2017 all exits were checked by the plant operations assistant. All exit doors were found to be functioning properly. On 4/11/17, all resident wanderguards were checked for placement and functioning by	

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F 323	Continued From page 66 Findings included: Resident #166 was in the hospital from 2/23/17 - 3/6/17. The Hospital Discharge Summary of 3/6/17 indicated the resident had a discharge diagnosis of a brain mass. He had a secondary diagnosis of seizures. The resident was discharged from the hospital and admitted to the facility on 3/6/17. His cumulative diagnoses included seizure disorder, difficulty in walking, muscle weakness, cognitive communication deficit. A review of the resident's medical record included a Nursing Admission Assessment completed on 3/6/17. The assessment included an Elopement Risk Evaluation, which indicated the resident was independently mobile, had the ability to exit the facility, but was determined to not be at risk for elopement. Resident #166 was assessed to be alert and oriented. A review of Resident #166's admission Minimum Data Set (MDS) assessment dated 3/13/17 revealed the resident had intact cognitive skills for daily decision making. No wandering behaviors were noted; one fall was reported within the last month prior to admission. The resident required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of being independent for eating. A review of the resident's Care Area Assessment (CAA) Summary dated 3/14/17 revealed the resident had a history of seizures and altered mental status during his hospitalization. No wandering behaviors were noted.	F 323	the Charge Nurses and Central Supply Clerk and all were properly functioning. All residents were reassessed for risk of elopement on 4/12/2017 by Assistant Director of Nursing, and Director of Nursing (DON). No new residents were identified as being at risk for elopement. Care plans and care cards were reviewed and updated as indicated for the 8 residents identified as being at risk for elopement on 4/21/2017 by Social Services Director, or Staff Development Coordinator (SDC). The binders which identify residents who are at risk for elopement were reviewed by the Administrator and Social Services Director to ensure that they were updated and in place at each nurse□s station and at the receptionist□s desk on 4/13/2017, all were found to be in place and correct. On 4/21/2017, Plant Operations Assistant contacted an outside vendor for service to dismantle the reset button located at the red hall nursing station. The service call for dismantling the reset button will be a part of the plan of correction. In the meantime, the reset button at red hall nursing station was covered and a sign was placed informing staff Do Not Use Button on 4/22/2107 at 1145 am, by Staff Development Coordinator and Plant Operations Assistant. 6 residents who are identified as residents who smoke have the potential to be affected by the alleged deficient practice. A review of the resident smoking area was completed by the Administrator and Maintenance Supervisor on 5/19/17. The	

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F 323	Continued From page 67 On 3/29/17, a Situation-Background-Appearance-Review (SBAR) Communication Form indicated the resident had a change in condition. The SBAR noted Resident #166 had a positive urinalysis for a urinary tract infection, with symptoms first noted on 3/25/17. The resident's mental status evaluation reported there was an increase in confusion or disorientation at that time. On 4/1/17, an Elopement Risk Evaluation was completed by Nurse #4. At that time, the resident was determined to be at risk for elopement. A review of Resident #166's medical record revealed a physician's telephone order was received on 4/1/17 to use a wander guard for the resident, check its placement and function every shift, and monitor the resident's whereabouts throughout the facility every 2 hours. A review of the resident's medical record included an SBAR Communication Form dated 4/2/17 and written by Nurse #4. The SBAR form reported Resident #166 had become combative and was attempting elopement. Nursing notes on the form indicated this change started on 3/30/17 and had gotten worse. The resident's Mental Status Evaluation noted the resident had an increase in confusion or disorientation; memory loss; and other symptoms or signs of delirium. Additional notes revealed the resident was more confused and unaware of where he was or why. The resident was noted to be uncooperative with staff and care and had tried to exit the facility unassisted in his wheelchair with no shoes on. The Nursing Narrative on the SBAR read as follows: "Resident became combative this AM (morning)	F 323	receptacle for cigarette butts was replaced with a red can that appropriately opens and closes. A larger sign was placed on the receptacle to specify that it was to be utilized only for cigarette butts. Another trash can was placed in the resident smoking area by the Maintenance Director on 5/19/17. The fire blanket was removed, cleaned, and replaced by the Maintenance Director on 5/19/17. C. Education on elopement policy including how to respond to door alarms, complete head counts, check wanderguard for function and placement, functioning of doors, and implementation of care plans related to triggered areas including elopement risk assessments, was initiated to all staff on duty on 4/21/2017 and will continue prior to all staff working next shift by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director (QOL), Minimum Data Set Coordinator (MDS), Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education on 4/21/17. Education and return demonstration on use of Accutech transmitter (device to check function of wander guard) to ensure staff competency of wander guard function and battery checks was initiated	

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F 323	Continued From page 68 with ADL care and started swinging at staff refusing any assist but was incontinent at the time. Two staff members were able to transfer Resident to wheelchair and get him to the restroom to provide AM care and put clothes on. Once getting into wheelchair resident took his shoes and sock back off and proceeded to front door to leave and redirected back inside facility where he began kicking at staff but able to get him to move away from front door. Resident then went to another exit door and proceeded to go out again and staff tried to redirect him telling him to wait for his family and he said he hadn't seen them in years and he was leaving now to go out. Resident continued to be barefoot at that time and kicked, hit and spit at staff. Resident was transferred back to bed with 3 staff members assist and PRN (as needed) given while staff sat at bedside until medication began to work and resident became quiet and sleepy. Once asleep family informed of events and wander guard placed on resident's leg." A review of Resident #166's care plan revealed the care plan had been updated on 4/3/17 to include an area of focus which indicated the resident was at risk for elopement as evidenced by exit seeking behaviors and attributed to cognitive deficits. Interventions listed on the care plan included: Use audible monitoring system to alert staff of exit seeking behavior (dated 4/3/17); Check audible monitoring system for proper functioning per policy (dated 4/3/17); and, 11:00 PM-7:00 AM sitter (not dated). Further review of the resident's medical record included an Interdisciplinary Note dated 4/10/17 at 2:43 PM, which read: "The resident is being reviewed by IDT (Interdisciplinary) Team for	F 323	on 4/22/2017 by the Plant Operations Director, Plant Operations Assistant, Central Supply Clerk/Certified Nursing Assistant, SDC, or Regional Nurse Consultant for licensed nurses and nurse aides. A post-test will be given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given. Staff that were not working on 4/22/2017 will be educated on the elopement policy and procedure, care plan and use of the Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A post-test will be given in which a passing score of 100% must be obtained. If 100% was not obtained the staff member will be re-educated and a post test will be reissued. The Administrator, DON, or Signature Care Consultant or regional team will review the Post Tests given weekly for any noted concerns. Any concerns will be addressed immediately. Staff who are As Needed, on the Family Medical Leave Act or on leave will not be allowed to return to work until they have received Elopement training, the post-test is administered and 100% score obtained. If employee did not score 100% on	

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F 323	Continued From page 69 Elopement/Wandering at this time as the resident due to current medical status and cognitive deficits tends to speak of leaving this place now and therefore has the wander guard in place with good results at this time. Continue with wander guard at this time." A review of Resident #166's medical record included an SBAR Communication Form dated 4/11/17. The SBAR form reported a change in the resident's condition occurred on 4/10/17, noting he had increased agitation, confusion and elopement. The SBAR reported the condition started on 4/10/17; the condition/symptom/sign had occurred before; and the treatment for the last episode was implementation of a wander guard. Resident #166's Mental Status Evaluation reported increased confusion or disorientation; memory loss; and other symptoms or signs of delirium. The Nursing Narrative for the SBAR read as follows: "Resident noted with increased agitation and confusion and even refused hour of sleep care. Resident noted with incoherent speech and was unable to follow directions. Resident scattered his belongings on the floor and then propelled himself out of the room. He apparently eloped through the main entrance. One of the staff members was going to her car at about 10:30 PM when she noted the resident trying to cross [Street Name] on a wheelchair. She brought the resident back to the building and informed this writer of what had transpired. Resident had wander guard to left ankle intact. Wander guard working well. Staff were asked to keep a close eye on the resident. [Name of practitioner service] on call paged and informed of resident's	F 323	post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. No newly hired employee will be allowed to work until education is provided, post-test administered and 100% score obtained. If employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 4/21/2017 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Assistant Directors of Nursing and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 4/21/2017 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Education was completed by the Staff Development Coordinator, Director of Nursing or Nurse Consultant by 5/31/17 for facility staff, to include nursing staff, dietary staff, housekeeping staff, and maintenance staff regarding the receptacle that is in the resident smoking area. Education included that the receptacle must only be utilized for cigarette butts. Staff were also educated	

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change in status. She gave an order for 0.5 mg Ativan po (by mouth) or IM (intramuscularly) x 1 (one dose). Resident already had Ativan 0.5 mg po ordered. Resident offered the medication and he took it. Resident's family called and notified of the proceedings and said that the companion would be here. The companion never showed up. Family called at 11:10 pm. At 11:15 pm, resident was observed propelling himself along the hallway towards the rehab hall. Resident tried to escape through the rehab hall but was brought back before he could exit the building. He did set off the alarm though. This nurse asked the resident if he was tired and was ready to go to bed. Resident stated he was ready to go to bed. The nurse assisted the resident to bed and he stayed in bed the whole shift. Resident checked on every hour while in bed. Will continue to monitor."

Further review of Resident #166's care plan revealed a hand-written notation on the care plan read: "4/11/17 Resident walked to parking area."

An interview was conducted on 4/20/17 at 4:15 PM with the Assistant Director of Maintenance. The Director of Maintenance was not available for an interview. The Assistant Director stated all exit doors had a key pad adjacent to the door. If the correct code was entered on the key pad, the door would open without activating the door alarm. If the correct code was not entered on the key pad and the release bar on the exit door was pushed, the door alarm would be activated. If the locked exit door's release bar was pushed for 15 seconds, the door would open. He reported the main entrance door was the only exit with a wander guard protection. If a resident with a wander guard came within 2 feet or so of the

regarding ensuring that the fire blanket is clean and available for use, and that a trash can has been placed in the resident smoking area for other trash items.
D. Beginning 04/22/2017 daily audits will be completed each shift by the Charge Nurse for wander guard functioning on all identified residents. Beginning 4/21/2017, the Plant Operations Director or the Plant Operations Assistant will check the exit doors in the facility daily for correct functioning and place on their log. Door function checks will be checked seven days a week for two weeks, then three times a week for 3 weeks by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. Beginning 4/21/2017, the Plant Operations Director or Plant Operations Assistant Department or the Charge Nurse will check functioning of wanderguards on all identified residents daily for two weeks. A Code Green Drill (Elopement Drill) was completed on 4/13/17 by the Maintenance Director, and will continue to be completed by the Maintenance Director, Administrator, Director of Nursing, or Staff Development Coordinator as follows: 1 daily on alternating shifts for one week; 3 times/week on each shift for one week; 2

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F 323	Continued From page 71 door, it would lock down. If the door was already open (as when a visitor goes out), the door would alarm. If a resident with a wander guard pushed on the front exit door for 15 seconds, it would unlock and continue to alarm until a code was entered into the key pad adjacent to the door. The Assistant Director of Maintenance stated the main entrance (front exit door) of the facility was locked at 9:00 PM to 5:00 AM daily. During that period of time, whether or not a resident had a wander guard, the front exit door would alarm when the door release bar was pressed. If the release bar was pressed for 15 seconds, the door would unlock to allow someone to exit. Upon inquiry, the Assistant Director reported there had been no problems with the door alarms during the 5 years he had worked at the facility. An observation was conducted on 4/20/17 from 4:25 PM through 4:39 PM. Accompanied by the Maintenance Assistant Director, the alarms on all 8 facility doors were tested and observed to be in working order. The main entrance door was tested with use of an activated wander guard. The wander guard initiated the door to lock as it was brought close to the doorway. When asked who would be responsible to respond to a door alarm if it was alarming, the Assistant stated, "everyone." He noted this was particularly important at night because there was less staffing on those shifts. An observation was conducted of Resident #166 on 4/20/17 at 5:00 PM. The resident was lying on his bed resting. He was dressed and well-groomed. The resident was noted to have a wander guard around his ankle. On 4/20/17 at 5:15 PM, an interview was	F 323	times/week on each shift for one week; 1 time/week on each shift for 4 weeks; 2 times/month on each shift for 4 weeks; 1 time/month on each shift for 4 weeks; 1 time/month on each shift each quarter. A Quality Assurance meeting will be held weekly beginning on 5/4/17, then weekly for 4 weeks, then monthly x 2 months for further follow up regarding the above stated plan. At that time based upon evaluation the QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing and ensure quality of care and quality of life is being delivered as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the Quality Assurance meeting will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or member of Regional staff weekly times 4 weeks then times 2 month. The Maintenance Director or Assistant Maintenance Director will complete rounds of the resident smoking area daily 5 times per week x 2 weeks, 3 times per week for 2 weeks, then once per week times 2 week to ensure that the red receptacle is in place and functional with the lid closed appropriately, as well as ensuring that the red receptacle is only being utilized for cigarette butts, that the fire blanket is clean and available for use, and that the trash can is available for	

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F 323	Continued From page 72 conducted with the facility's Administrator. Upon inquiry, the Administrator reported he was aware the resident exited the building the previous week. The Administrator stated the resident had a lot going on and was very anxious. The Administration stated, "It was an isolated incident." He reported the resident had a sitter but the sitter had called in and was not present at the time of the exit. When asked what was done after the elopement, the Administrator stated the resident's anxiety level was the first issue to be addressed. Next, he reported the facility staff had to be sure to check on him more often. He stated the resident had settled down quite a bit since. He also reported the exit of the building was discussed in the staff's morning meeting. When asked if anything else was implemented to protect other residents, the Administrator stated "No," and reiterated this was an isolated incident. An interview was conducted on 4/20/17 at 6:05 PM with the facility's Director of Nursing (DON). Inquiry was made regarding the incident on 4/10/17 when Resident #166 exited the building unattended. The DON stated that based on camera surveillance, the resident went to the facility's front door and pushed on it, the alarm sounded, then he came back up the hallway, turned around again and came back to the door 3-4 minutes later. She stated the alarm had not been reset with a code so it did continue to alarm. The DON reported that shortly after the alarm sounded, a Nursing Assistant (NA) went out the door, reset the alarm, and then saw the resident outside. When asked how many minutes had elapsed between when Resident #166 went outside and when he was seen, the DON reported she would need to check on the time frame. When asked if an investigation was done	F 323	other trash items. Findings of the rounds will be reported to the Administrator to ensure corrective action is completed immediately for identified concerns. Findings of the rounds will be discussed by the Maintenance Director with the QAPI Committee monthly for 3 months to ensure continued compliance and for recommendations and further follow-up as indicated.	

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of the incident, she stated, "of sorts."

An interview was conducted on 4/21/17 at 7:38 AM with Nurse #1 who worked the evening of 4/10/17 at the time Resident #166 exited the facility. The nurse stated the resident had anxiety when she first came on the shift and she had asked NA #2 to keep an eye on him. At about 9:30-10:00 PM that evening, she recalled going to check on the resident. He was in his room rolling around and pulling on "stuff." At that point, she again told NA #2 to please keep a close eye on him. The nurse stated she was at the 200 Hall nursing station doing an admission for a new resident when she heard the facility's front door alarm go off. She stated that was around the time the next shift of staff came in and explained that if a staff member coming into the facility put in the code and pushed on the door bar too soon, the alarm would sound. Nurse #1 stated she could turn off the facility's front door alarm from the nursing station, so she did without identifying the cause of the alarm and she continued to do her work. The nurse recalled "less than 30 minutes later," she saw NA #1 pushing the resident down the hall in his wheelchair. NA #1 told the nurse he was outside and was about to cross the road [Street Name]. She asked the NA if he had a wander guard on and he did. The nurse stated they figured out he had pushed on the door long enough to make it open. The resident was reported as confused at that time and he was placed in his wheelchair by the nurse's station for supervision. The nurse observed the resident propel himself down the Rehab hall. He tried to open that exit door and it alarmed; however, staff reached him before he was able to actually open the exit door. Resident #166 stated he was tired at that point and the

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nurse assisted him to bed. When asked how often the front door alarm was activated each night after being locked at 9:00 PM; the nurse stated "pretty often." Upon further inquiry, she indicated the alarm was activated more than once a night, and she would have to either reset the alarm from the Nursing Station or enter the code at the door. Upon further inquiry, the nurse reiterated the resident had a wander guard on and the alarm on the door was working. When asked what staff was supposed to do when a door alarm sounded, the nurse stated they were supposed to go and check the door because they need to check on who is going out the facility's door.

An interview was conducted on 4/21/17 at 8:10 AM with the DON upon her request. The DON stated the door alarms could not be deactivated at the Nursing Station. The only way to silence the alarm was by putting in a code at the door itself.

A follow-up interview was conducted on 4/21/17 at 8:15 AM with Nurse #1. Upon request, the nurse pointed out the location of the reset button used to deactivate the facility's front door alarm at the 200 Hall Nursing Station.

A follow-up interview was conducted on 4/21/17 at 9:20 AM with the Assistant Director of Maintenance.
Upon inquiry, the Assistant stated he had heard about the incident when Resident #166 exited the building on 4/10/17. He reported the Maintenance Director had gotten the camera feed for review. The camera surveillance included only video (no audio). When asked, the Assistant Director confirmed that after 9:00 PM (with or

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without wearing a wander guard), any push on the door bar would sound the alarm. Upon inquiry as to how the alarm would be silenced, he stated someone would need to enter the code at the door. When asked about the reset button located at the 200 Hall Nursing Station used to silence an alarm, the Assistant Director stated, "That would be news to me."

An observation was conducted on 4/21/17 at 9:27 AM. Accompanied by one surveyor, the Maintenance Assistant Director used a wander guard to activate the alarm on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button (identified by Nurse #1) was pushed, the alarm was silenced. However, someone entered the building at that time so it was unclear as to whether or not the alarm was silenced by the guest entry or by pushing the button at the Nursing Station. A second observation was made on 4/21/17 at 9:30 AM. Accompanied by a surveyor, the Assistant Director of Maintenance again used a wander guard to activate the alarm on the main entrance door. A second surveyor located at the 200 Hall Nursing Station observed when the reset button was pushed, the alarm stopped. The Assistant Director of Maintenance stated at that time, "She must have cut it off."

On 4/21/17 at 9:32 AM, the Assistant Maintenance Director and Unit Manager #1 were interviewed in regards to the button used to deactivate the door alarm. The Unit Manager stated she had worked at the facility for 4 years and did not know about the button. The Assistant Director of Maintenance stated, "That's not good to have."

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On 4/21/17 at 10:45 AM, a telephone interview was conducted with NA #1. NA #1 was identified as the nursing assistant who found the resident outside of the building. NA #1 reported on 4/10/17, she worked from 7:00 AM to 11:00 PM. NA #1 recalled hearing the loud alarm that evening (the sound that occurs past the warning beeps during the first 15 seconds upon activation of the door alarm). She was in the back of the 100 Hall at the time. The NA stated within 1-2 minutes after the alarm sounding, she went to the front door to specifically put in the code and turn off the alarm. She stated she was not going to her car. No one was around the main entrance door, so she went outside to look around. She reported seeing a man in a wheelchair on the sidewalk, just past the Rehab awning facing [Street Name.]. The NA stated she discovered it was Resident #166 so she brought him back into the building. When asked how long the resident would have been out of the building (between the time the alarm sounded and when she brought him back in), she stated, "1-2 minutes." Upon inquiry about the longer time frame noted by the facility (based on camera surveillance), the NA stated she, "didn't know about that" and stated she responded to the loud door alarm "in a couple seconds."

On 4/21/17 at 11:24 AM, a telephone interview was conducted with the Nurse #4. Nurse #4 had worked with the Resident #166 on 1st shift on 4/1/17 and 4/2/17. Nurse #4 recalled Resident #166 had tried to exit from the front door. At that time, he did not have a wander guard. However, there were people in the lobby and he was redirected. He then tried to exit near Rehab and activated the door alarm there. Nurse #4 stated staff were able to stop him from going out the

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door. However, based on what she had seen, the nurse stated she went ahead and updated the resident's Elopement Evaluation, and also called the family and Nurse Practitioner (NP). The NP reported the resident already had an order for an antianxiety medication to be used as needed for periods of agitation. A telephone order was received to initiate the use of wander guard. During the interview, the nurse was asked how she could deactivate a door alarm. Nurse #4 stated, "The only way I know is to go to the door to (enter the code and) deactivate the alarm. That's how we knew he was trying to exit the door."

Accompanied by the Assistant Maintenance Director and the Corporate Nurse Consultant, the camera surveillance video from evening of 4/10/17 was viewed on 4/21/17 at 1:26 PM. The Assistant Maintenance Director reported while the date on the camera surveillance monitor was correct, the time stamp was off and 32 minutes needed to be added to the time stamp to get the correct time from the surveillance. The camera surveillance video from 4/10/17 (with the corrected times) revealed the following:
--At 10:25 PM (corrected time), Resident #166 was observed as he pushed on the front entrance door. Upon viewing this portion of the video, the Assistant Director of Maintenance stated the alarm would have gone off at that time.
--Resident #166 was observed as he sat in his wheelchair in front of the door for 1-2 minutes.
--At 10:27 PM (corrected time), the resident was observed as he proceeded back down the facility hallway.
--At 10:27 PM (corrected time), Resident #166 re-approached the front entrance door.
--At 10:28 PM (corrected time), the resident was

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observed as he opened the front exit door and went through first door, then the second door to get outside of the facility.
--At 10:32 PM (corrected time), a staff member (identified as NA #1 by the Corporate Nurse Consultant) opened both doors and stood outside of the facility's front entrance door. The NA was observed with a purse over her shoulder, a light jacket tied around her waist, and holding her cell phone. Initially upon exiting the building, the NA was observed to be using and/or viewing a cell phone. She was out of view of the camera for brief periods of time.
--At 10:36 PM (corrected time), an unidentified man came to the front entrance door and entered the building.
--At 10:36 PM (corrected time), NA #1 was observed as she came back in the building, pushing the resident in his wheelchair.

On 4/21/17 at 1:45 PM, the facility's DON joined the Assistant Director of Maintenance as the camera surveillance and timeline from 4/10/17 were being discussed. An interview was conducted with the DON at that time. During the interview, the DON stated she had worked at the facility for 12 years and did not know there was button at the Nursing Station to disarm the door alarm. At that time, the Assistant Director of Maintenance was asked in the presence of the DON if the reset button at the 200 Hall Nursing Station worked to silence the alarm. He stated, "Yes it did." When the DON asked him if it actually deactivated the alarm, the Assistant Director of Maintenance confirmed the button did deactivate the alarm when it was tested. Upon inquiry, the DON stated the reset button should "Never, ever" be used. She reported her expectation would be for the staff to immediately

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investigate why a door alarm was activated.

An observation was made on 4/22/17 at 9:52 AM as NA #1 identified the location of Resident #166 when he was found outside on 4/10/17. At that time, the Assistant Director of Maintenance measured how far the resident was from the front door entrance where he exited the facility, and how far the resident was from the street when he was found. Measurements determined the resident had traveled 108 feet from the front entrance of the facility. The resident was reported to be facing a 5-lane street directly in front of the facility at the time he was found. Measurements revealed Resident #166 was 109 feet from the curb adjacent to the street.

A telephone interview was conducted on 4/22/17 at 11:47 AM with NA #2. NA #2 was the 2nd shift nursing assistant assigned to care for Resident #166 at the time he exited the facility on the evening of 4/10/17. Upon inquiry as to what she recalled about the evening of 4/10/17, the NA reported she knew the resident kept going to the front door of the facility. However, she did not know Resident #166 actually got out of the facility. When asked if the door alarm went off that evening, NA #2 stated, "Yes, that's how we knew he was going to the door." Upon inquiry, the NA recalled the door alarm only went off for a few seconds at a time that evening (not minutes).

On 4/21/17 at 2:32 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 4/22/17 at 4:05 PM. The allegation of compliance indicated:

Credible Allegation for F323

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A. Resident # 166 was noted by staff to be outside on the sidewalk by the rehab side of the building on 4/10/2017.
Resident # 166 was assisted back to the facility by the Certified Nursing Assistant on 4/10/2017 at approximately 10:04 PM. and placed at the nurses' station for closer monitoring at approximately 10:05 PM. The Charge Nurse assisted the resident to bed. The Charge Nurse changed the bed linens and provided incontinent care for the resident. The nurse performed an assessment on resident #166 during care, no new injuries were noted at this time. The Resident's responsible party and physician were notified of incident by the charge nurse on 4/10/17. Resident #166 was monitored every hour for the rest of the night by the charge nurse.

B. A head count of the entire facility was conducted on 4/11/2017 at 12:00 midnight by the charge nurses. All residents were accounted for and were safe. On 4/11/2017 all exits were checked by the plant operations assistant. All exit doors were found to be functioning properly. On 4/11/17, all resident wander guards were checked for placement and functioning by the Charge Nurses and Central Supply Clerk and all were properly functioning. All residents were reassessed for risk of elopement on 4/12//2017 by Assistant Director of Nursing, and Director of Nursing. No new residents were identified as being at risk for elopement. Care plans and care cards were reviewed and updated as indicated for the 8 residents identified as being at risk for elopement on 4/21/2017 by Social Services Director, or Staff Development Coordinator. The binders which identify residents who are at risk for elopement were reviewed by the Administrator and Social Services Director to ensure that they

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were updated and in place at each nurse's station and at the receptionist's desk on 4/13/2017, all were found to be in place and correct. On 4/21/2017, Plant Operations Assistant contacted an outside vendor for service to dismantle the reset button located at the red hall nursing station. The service call for dismantling the reset button will be a part of the plan of correction. In the meantime, the reset button at red hall nursing station was covered and a sign was placed informing staff "Do Not Use Button" on 4/22/2107 at 1145 am, by Staff Development Coordinator and Plant Operations Assistant.

C. Education on elopement policy including how to respond to door alarms, complete head counts, check wander guard for function and placement, functioning of doors, and implementation of care plans related to triggered areas including elopement risk assessments, was initiated to all staff on duty on 4/21/2017 and will continue prior to all staff working next shift by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education on 4/21/17. Education and return demonstration on use of Accutech transmitter (device to check function of wander guard) to ensure staff competency of wander guard function and battery checks was initiated on 4/22/2017 by the Plant Operations Director, Plant Operations Assistant, Central Supply Clerk/Certified Nursing Assistant, SDC, or Regional Nurse Consultant for licensed

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nurses and nurse aides. A post-test will be given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given. Staff that were not working on 4/22/2017 will be educated on the elopement policy and procedure, care plan and use of the Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A posttest will be given in which a passing score of 100% must be obtained. If 100% was not obtained the staff member will be re-educated and a post test will be reissued. The Administrator, DON, or Signature Care Consultant or regional team will review the Post Tests given daily until immediacy removed and then weekly for any noted concerns. Any concerns will be addressed immediately. Staff who are As Needed, on the Family Medical Leave Act or on leave will not be allowed to return to work until received Elopement training, the post-test is administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This process will continue until employee obtains a 100% score on post-test. No newly hired employee will be allowed to work until education is provided, post-test administered and 100% score obtained, if employee did not score 100% on post-test, then employee will be immediately re-educated and post-test re-administered. This

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process will continue until employee obtains a 100% score on post-test. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 4/21/2017 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 4/21/2017 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Beginning 04/22/2017 daily audits will be completed each shift for wander guard functioning on all identified residents. Beginning 4/21/2017, the Plant Operations Director or the Plant Operations Assistant will check the exit doors in the facility daily for correct functioning and place on their log until immediacy removed. Door function checks will continue to be checked seven days a week for two weeks, then three times a week for 3 weeks by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. Beginning 4/21/2017, the Plant Operations Director or Plant Operations Assistant Department or nursing will check functioning of Wander guards on all identified residents daily for two weeks. A Code Green Drill (Elopement Drill) was completed on 4/13/17 by the Maintenance Director, and will continue to be completed by the Maintenance Director, Administrator, Director of

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F 323	Continued From page 84 Nursing, or Staff Development Coordinator as follows: 1 daily on alternating shifts for one week; 3 times/week on each shift for one week; 2 times/week on each shift for one week; 1 time/week on each shift for 4 weeks; 2 times/month on each shift for 4 weeks; 1 time/month on each shift for 4 weeks; 1 time/month on each shift each quarter. Regional Care Consultant Staff are providing oversight to the audits three times a week beginning 4/21/2017. The elopement policy and procedure, missing resident, care plans and Accutech will be in serviced in orientation for all new hires in which a post test will be given and a score of 100% must be obtained. Facility alleged IJ removal on 4/22/2017 The credible allegation was verified on 4/22/17 at 7:04 PM. On 4/22/17 from 6:36 PM through 7:04 PM, staff members from the Nursing (both nurses and nursing assistants), Maintenance, and Dietary Departments were interviewed. Staff were able to describe the education received on resident elopement, how to respond when the door alarm was activated, and how to verify a resident's wander guard was in working order. Care Plans and Care Guides of a resident sample determined to be at risk for elopement were reviewed and each noted to have been updated. A Binder containing information on the residents identified as being at risk for elopement was in place at each Nursing Station and at the Reception's Desk. The reset button located at the 200 Hall Nursing Station (which deactivated the front door alarm) was observed on 4/22/17 at 6:54 PM to have been taped over with a large note placed in front of it which read in capital letters, "DO NOT USE (RESET) BUTTON." The immediate jeopardy was removed on 4/22/17 at	F 323		

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F 323	Continued From page 85 7:23 PM. 2) An observation of the designated smoking area for residents on 4/18/2017 at 2:30 pm revealed the smoking area was outside in a contained courtyard. The section of the courtyard designated for residents to smoke contained a red receptacle with the lid open; there was a handwritten note on the lid of the receptacle that stated "cigarette butts only". The receptacle was approximately half full and contained cigarette butts and paper trash items (empty cigarette pack, and foam cups). There was no other receptacle available for trash noted in the smoking area. A fire blanket was in a container attached to a wall in the courtyard; it was noted to be covered in a birds nest. An observation on 4/18/17 at 3:55 pm of the designated smoking area for residents revealed the receptacle for extinguishing cigarettes was open and contained cigarette butts and paper trash items. There was no other receptacle available for trash noted in the smoking area. A bird was observed flying out of the nest that was built on the fire blanket; upon closer observation it was noted that there were 5 eggs in the birds nest. An interview with the administrator on 4/18/17 at 4:00 pm revealed that there should not have been any trash in the receptacle designated for cigarette butts. He stated he was not aware that there was not a trash can in the smoking area or that the fire blanket was covered in a birds nest. He stated all of these areas needed to be corrected.	F 323		
F 332	483.45(f)(1) FREE OF MEDICATION ERROR	F 332		6/5/17

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F 332 SS=D	Continued From page 86 RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to have a medication error rate less than 5% as evidenced by 2 medication errors out of 28 opportunities, resulting in a medication error rate of 7.1%, for 2 of 4 residents (Resident #86 and Resident #14) observed during medication pass. The findings included: 1) A review of the facility ' s Policy and Procedures included, "Medication Administration Enteral Tubes" (Dated 12/12) included the following procedural steps: "2. Prepare medications for administration. a) Consult crush guidelines before crushing tablets. Crush tablets into a fine powder and dissolve in at least 5 ml of water or other appropriate liquid. b) Empty capsule contents into at least 5 ml of water or other appropriate liquid." On 4/20/17 at 9:10 AM, Nurse #2 was observed as she pulled medications from the medication cart for administration to Resident #86 via a gastrostomy tube (a feeding tube put directly into the stomach). The medications pulled for administration included the following: one - 500	F 332	F332: A. An assessment was completed by the Unit Manager on 4/20/17 for Resident #86 to ensure his gastrostomy tube was patent following the administration of powdered medication. The gastrostomy tube was found to be patent and functioning properly. A competency for gastrostomy tube medication administration was completed by the Staff Development Coordinator for Nurse #2 to ensure understanding of the requirement to dissolve powered medications in water prior to administration through a gastrostomy tube, and the requirement that a water flush must occur between each medication. Nurse # 3 received re-education regarding administration of nasal spray as ordered. B. All other residents with gastrostomy tubes and receiving medication via nasal spray have the potential to be affected by the alleged deficient practice. No other concerns were identified. C. Licensed Nurses received re-education by the Staff Development Coordinator for safe and effective administration of medication per facility	

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F 332	Continued From page 87 milligram (mg) metformin tablet (an antidiabetic agent); one - 5 mg lisinopril tablet (an antihypertensive medication); one capsule of lactobacillus acidophilus (a probiotic); 10 milliliters (ml) of 0.2 mg/ml glycopyrrolate (a medication used to reduce secretions); a multi-dose eye drop bottle of 1.4 % artificial tears (an eye drop used for dry or irritated eyes); and, one - 1.5 mg Transderm-Scop transdermal (skin) patch (frequently used for the prevention of nausea from motion sickness). Nurse #2 was observed as she crushed the metformin and lisinopril tablets separately and placed each of the crushed medications into a separate medication cup. She opened the lactobacillus acidophilus capsule and poured the contents of the capsule into a 3rd medication cup. No water was added to the medication cups to dissolve the powdered medications. On 4/20/17 at 9:20 AM, Nurse #2 was observed as she brought the medications to Resident #86 ' s room. The nurse checked the resident ' s tube for residuals and gastrostomy tube placement. She attached a syringe to the tubing and instilled 30 ml of water into the tube to flush the tubing. The nurse poured a dry white powder (one of the medications that had been crushed but not dissolved in water) from one of the medication cups into the syringe, and then poured 5 ml water into the syringe. She repeated this process with the next medication that had been crushed into a powder, followed with 5 ml of water. The nurse then poured the glycopyrrolate liquid into the syringe and followed it with 5 ml of water. Next, Nurse #2 poured the dry contents of the opened capsule from the last of the three medication cups into the syringe, followed by 30 ml water to flush the tubing after all of the medications had	F 332	policy regarding administration of medication through a gastrostomy tube, to include the requirement of dissolving powered medication in water prior to administration through the gastrostomy tube, and that a water flush must occur between each medication. Re-education. License Nurses also received re-education regarding safe and effective administration of medication given via nasal spray per order. Re-education was completed by the Staff Development Coordinator for licensed nurses by 5/31/17. This education will be ongoing provided upon hire and annually. D. The Staff Development Coordinator, Assistant Director of Nursing, Licensed Nurse, and Director of Nursing will complete gastrostomy tube medication administration audit when medications are administered via enteral tube and administration of nasal spray as ordered. This will be executed on varied shifts including weekends for 4 Licensed Nurses per week x 2 weeks, then 2 licensed Nurse per week x 2 weeks to ensure compliance. Any issues or trends identified will be addressed by Quality Assurance Performance Improvement committee as they arise and the plan will be revise to ensure continued compliance.	

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been administered. The dry powdered medications and water were noted to be draining down the tube very slowly and a pink substance approximately ¾" long was observed within the tubing, approximately 2" down from the syringe connection. The pink substance appeared to be plugging the tube. After 1-2 minutes, the plug floated back up into the syringe. Nurse #2 used two additional 5-10 ml flushes to try and dissolve the substance and promote the flow back down the tubing. The nurse reported the contents from the capsule (the probiotic) was the "plug" that stopped the tube from draining into the resident ' s stomach. The nurse stated this was the first time she had run into the situation where the medications instilled so slowly through the tubing. Nurse #2 also reported this resident ' s tube had just been replaced the previous week. Resident #86 was observed as the eye drops were instilled and the transdermal patch was applied to her skin.

An interview was conducted on 4/20/17 at 11:55 AM with Nurse #2. Upon inquiry, Nurse #2 stated the procedures she followed for medication administration via a gastrostomy tube were the usual procedures she used for administering the medications via a tube. The nurse reported the procedures she used were in accordance with the facility ' s recommended procedures.

A follow-up interview was conducted on 4/20/17 at 12:16 PM with Nurse #2. The nurse was shown the facility's policy and procedures indicating crushed medications and capsule contents should be dissolved in a medication cup prior to administration via a tube. Nurse #2 reported she had been in-serviced earlier that morning in regards to medication administration

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via a tube, and was told to follow the procedures observed during med pass. At that time, Unit Manager #1 joined the discussion. When asked, the Unit Manager reported she had understood crushed meds (and capsule contents) needed to be dissolved in a small amount of water prior to administration via a tube. The practice observed when the nurse poured a dry powdered medication into a syringe attached to the tubing, then 5 ml of water, then another dry powdered medication on top of that was discussed. Upon inquiry, the Unit Manager acknowledge this practice would not provide a water flush between the individual medications.

An interview was conducted on 4/20/17 at 12:30 PM with the facility ' s Director of Nursing in the presence of the Corporate Nurse Consultant. Inquiry was made as to the morning in-servicing on medication administration via tube and the intent of the instructions provided. Both the DON and Nurse Consultant stated the crushed meds or contents of a capsule needed to be dissolved in a small amount of water prior to pouring the medication into the syringe and, a water flush should be used between each individual medication given.

2. Medical record review for Resident #4 revealed Physician orders dated March 23, 2017 through April 23, 2017 for Fluticasone Propionate Fluticasone Propionate (drug used to treat rhinitis) 1 (one) spray in each nostril daily.

Observation of Nurse #3 during the medication pass on 4/20/17 at 9:26 AM revealed Resident #4 was administered Fluticasone Propionate 2 (two)

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F 332	Continued From page 90 nasal sprays in the left nostril. Interview on 04/20/2017 at 9:43 AM with Nurse #3 revealed she thought that she had sprayed Fluticasone Propionate into both nostrils but knew that the order was for 1 spray of Fluticasone Propionate in each nostril. Interview on 04/22/2017 at 4:19 PM with the Administrator revealed he expected medications be administered as prescribed.	F 332		
F 333 SS=E	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on consultation report reviews, facility record reviews, and staff and physician interviews, the facility failed to administer an antibiotic and antifungal medication for 14 days after the medications were recommended by an Infectious Disease consultant and approved by the resident ' s physician. This occurred for 1 of 6 sampled residents (Resident #134) reviewed for unnecessary medications. The findings included: Resident #134 was admitted to the facility on 1/31/17 from the hospital. His cumulative diagnoses included osteomyelitis (infection and inflammation in the bone) of the vertebra (series	F 333	F333: A. The Physician for Resident #134 was notified of the medication error on 3/29/17. An order was received to start the medication and continue as previously ordered. Medication administration was initiated 3/29/17. B. Residents who required consultation from outside physicians have the potential to be affected by the alleged deficient practice. Orders and consultation reports for Residents who have had consultation from outside physicians for the last 6 months were reviewed by the Director of Nursing, Unit Coordinator, Licensed Nurse or Nurse Consultant on 4/25/17 to	5/31/17

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F 333	Continued From page 91 of small bones forming the backbone). A review of Resident #134 ' s admission Minimum Data Set (MDS) assessment dated 2/7/17 revealed the resident had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance for all of his Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating and locomotion on/off the unit. Section N of the MDS assessment indicated the resident received an antibiotic on 7 out of the 7 days during the look back period. A review of the resident ' s Care Plan dated 2/10/17 included the following area of focus: Resident is at risk for complications related to the use of intravenous fluids or intravenous medications. A review of Resident #134 ' s medical record included a consultation report from an Infectious Disease (ID) clinic dated 3/15/17. The Report of Consultation revealed Resident #134 was seen for follow-up of vertebral osteomyelitis. At that time, the Infectious Disease consultant recommended stopping the intravenous antibiotic and initiating oral antibiotics, including 100 milligrams (mg) doxycycline (an antibiotic) to be given by mouth twice daily and 400 mg fluconazole (an antifungal agent) to be given by mouth once daily. A review of the resident ' s March 2017 Medication Administration Record (MAR) revealed an order for 750 mg vancomycin (an intravenous antibiotic) administered once daily was discontinued on 3/15/17. Further review of the March 2017 revealed doxycycline and	F 333	ensure appropriate follow-up and initiation of medication as ordered. No other concerns were identified. C. Education will be completed by 5/31/17 by the Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing or Nurse Consultant for licensed nurses regarding reviewing orders and consultation reports upon return of the resident to the facility following a consultation. Education also included ensuring orders were appropriately transmitted to the pharmacy and medications were initiated as ordered. Residents who require outside consultation will be discussed in the daily clinical meeting by the Interdisciplinary Team (Director of Nursing, Unit Managers, Social Services Director, Dietary Director, Wound Care Nurse, Quality of Life Director, and Chaplain) to ensure appropriate follow-up and initiation of medication as ordered. D. The Director of Nursing, Assistant Director of Nursing Unit Coordinator, Staff development Coordinator, or Nurse Consultant will complete an audit for physician consultation reports for 5 resident□s, 5 times a week times 2 weeks, then 3 times per week for 2 weeks, then weekly for 2 weeks to ensure medications have been initiated according to physician□s orders and orders received through consultation. Findings will be reported to the Director of Nursing to ensure immediate correction of identified concerns. Unit Managers will discuss findings of the above stated audits with the Quality Assurance Performance	

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fluconazole were not initiated until 3/29/17 at 9:00 PM.

A review of Resident #134 ' s medical record revealed the resident was seen by her physician on 3/16/17. The physician ' s Progress Note read, in part:
" ...He was recently seen in infectious disease clinic for vertebral osteomyelitis. MRI was obtained which showed improvement. Antibiotic IV vancomycin is discontinued, he was started on doxycycline 100 mg twice a day and fluconazole 400 mg daily ..."

A review of the Nursing Progress notes revealed a notation was made on 3/29/17 at 6:57 PM which read, in part:
"Resident approached writer with consultation form dated 3/15/17. Resident stated the physician ordered him medications but medications were sent to wrong pharmacy. Writer attempted to contact consulting physician (MD Name) but was unable to speak with them, message was left with consulting physician return call pending ..."

A Nursing Progress note dated 3/29/17 at 8:30 PM revealed a return call was received from the consulting physician from the ID clinic. The note indicated the oral antibiotics were to be started and continued for 6 months.

A review of the next consultation report from the ID clinic revealed the resident was seen on 4/10/17. The Report of Consultation included the following notation: "Facility did not administer doxy (doxycycline) and Diflucan (brand name for fluconazole) for 2 wks (weeks) after last visit as did not check my note. Rectified." The ID clinic

Improvement Committee (QAPI) monthly for recommendations and further follow-up as indicated.

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recommendations included continuation of the doxycycline and fluconazole as previously ordered.

An interview was conducted on 4/22/17 at 4:10 PM with the facility ' s Consultant Director of Nursing (DON). Upon review of Resident #134 ' s medical record, the Consultant DON confirmed the March 2017 MAR indicated the doxycycline and fluconazole were not initiated until the evening of 3/29/17. Upon inquiry as to whether an investigation had been done or a medication error report completed for this situation, the Consultant DON reported she would need to check.

A telephone interview was conducted on 4/22/17 at 4:22 PM with Resident #134 ' s physician (who was also the facility ' s Medical Director). During the interview, the physician recalled she had initialed the 3/15/17 ID consult report (initialed on 3/16/17) to show she had reviewed it. The physician also recalled inquiring about the oral medications and stated she was told these would be started. "When consults come in, I verify the orders." The MD stated she would have expected the nurses to carry out the new orders as prescribed. When asked if there may have been harm caused for this resident by the delay in starting the oral antibiotics, the physician stated so she could not say there was harm. She reported the resident had been monitored and did not experience fevers or unusual swelling.

A telephone interview was conducted on 4/22/17 at 4:41 PM with a pharmacy technician from the facility ' s contracted pharmacy. Upon inquiry, the pharmacy technician reported doxycycline and fluconazole were each sent out one time only (on

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F 333	Continued From page 94 3/30/17) for Resident #134 during the month of March 2017. Accompanied by the facility ' s interim DON, an observation of the facility ' s emergency medications was conducted on 4/22/17 at 4:47 PM. At that time, it was revealed the emergency supply of medications included 6 - 100 mg doxycycline 100 capsules, 10 - 100 mg doxycycline; 6 - 100 mg fluconazole tablets and 7 - 150 mg fluconazole tablets. No record was available for review to determine how many (or if any) of the medications administered to Resident #134 came from the facility ' s emergency supply of these medications. An interview was conducted on 4/22/17 at 4:51 PM with the interim DON. During the interview, the DON reported any medication given to the resident would be recorded on the MAR when it was administered, even if the medication came from the emergency supply. Upon inquiry, the interim DON indicated she would expect nurses to follow the facility ' s process when a resident returned to the facility after having an outside consultation. She reported a consult report should be brought back to the facility with the resident, and the new orders would need to be reviewed by the physician. If the physician approved an order, the nurse was expected to write that order (either via a Telephone Order or Verbal Order) and then put it into the computer system to initiate any changes in the resident ' s medications.	F 333		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services	F 353		5/31/17

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F 353	Continued From page 95 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and	F 353		

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F 353	Continued From page 96 described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews and observations, the facility failed to provide sufficient nursing staff to provide Activities of Daily Living (ADLs) for 3 of 8 residents reviewed for ADLs (Resident #36, Resident #24, Resident #97). Findings included: The staffing schedules and Nurse Aides' (NA) hours worked for Blue hall is as follows: Saturday 4/15/17: 3 NA scheduled for Blue hall 7:00 AM to 11:00 PM. 2 NAs called out for Blue hall. 1 NA scheduled for the entire facility from 11:00 PM to 7:00 AM. 2 NA scheduled for Blue Hall 1:00 AM to 7:30 AM. Both NA came in late for 3rd shift for blue hall. Sunday 4/16/17: 3 NAs scheduled on Blue hall from 7:00 AM to 3:00 PM. 2 NAs called out for Blue hall. 1 NA scheduled on Blue hall from 3:00 PM to 7:00 pm and 1 NA scheduled from 3:00 pm to 8:00 PM. 1 NA scheduled for Blue hall from 3:00 PM to 11:00 PM. 4 NAs called out. 2 NAs scheduled for Blue hall from 11:00 AM to	F 353	F353: A. Interview was completed by 5/19/17 by the Director of Nursing (DON) for resident #24, and #36 regarding the alleged deficient practice of lack of sufficient staffing and the residents care needs are met through staff education and sufficient staffing; resident # 97 no longer resides in the facility. The nursing schedule is being reviewed daily by the Administrator (ADM), Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Coordinator (UC) to assure that daily staffing levels are appropriate to meet resident care needs. The Administrator, DON, or Unit Coordinator, will daily determine the number of staff needed for the 24 hour period based on facility census and resident acuity. B. All residents with Brief Interview Mental Status (BIMS) 8 or > were interviewed to assure their care needs are being met, this was completed on 5/19/17 by the Admission Coordinator, Social Service Director, Quality of Life Director, Chaplain, Assistant Director of Nursing, Director of Nursing, Unit Coordinator, Rehabilitation Service Manager or Nurse Consultant. Any concerns identified will be addressed. All residents with BIMs 7 or < were assessed to assure that their	

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F 353	Continued From page 97 7:00 AM. 1.) Resident #36 had the following diagnoses of spinal stenosis, anemia and hypertension. Resident #36's Minimum Data Set dated 3/30/17 revealed the resident was moderately cognitively impaired. The resident required total dependence for bathing. The resident had a care plan in place last updated 3/12/17 for ADLs self-care deficit. A list provided by the Social Worker of all alert and oriented residents revealed that resident #36 was alert and oriented. The resident was residing on blue hall. Review of #36's shower days revealed the resident's shower days were scheduled for Wednesday and Saturdays. Review of the resident's Activities of Daily Living flow sheet and the shower assignment sheets revealed the resident did not receive a shower or any kind of bath on Saturday 4/15/17. There were no notes that revealed the resident got a shower or bath of any kind on Saturday 4/15/17. Nursing Assistant #6 was interviewed on 4/20/17 at 11:12 PM. She stated she worked from 3:00 PM to 11:00 PM and then 11:00 PM and 7:00 PM over the weekend. She worked last Saturday and Sunday night (April 15 - 16, 2017). She came in to help them out. She stated they were short staffed on all shifts on Saturday and Sunday. She stated on Saturday from 3:00 PM to 7:00 PM they had 3 nurse aides (NA) for the entire building and then from 7:00 to 11:00 PM they only had 2 NAs for the whole building. She stated that administration was putting extra people on the	F 353	care needs are being met as outlined per the residents care plan by the DON, ADON, UC, or Nurse Consultant This was completed by 5/19/17 Any findings were forwarded to the DON. Corrective actions were completed as indicated. C. Education to be completed by 5/31/17 by the Staff Development Coordinator (SDC), DON, or Regional Nurse to include nursing staff (Licensed Nurses and Certified Nursing Assistant) to address the importance of and policy expectations of meeting residents care needs to include bathing/showers, incontinent care and any other reasonable care needs the resident may have. Secondly, the Administrator, DON, ADON, Unit Coordinator, Licensed Nurse will review daily staffing sheet to ensure sufficient staffing is scheduled to meet the care needs of each resident. D. Care delivery audits will be completed for bathing/showers, and incontinent care; audits will be conducted 5 residents per day x 4 weeks, 3 per day x 4 weeks, then once weekly x 4 weeks. Any deficit in care delivery or trends identified will be addressed by the Quality Assurance Performance Improvement committee (QAPI) as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, Minimum Data Set Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Services.	

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schedule that were not actually here. She stated she got the residents up that had to get up for aspiration precautions, but many residents had to just eat in their beds over the weekend.

Nursing Assistant #5 was interviewed on 4/22/17 at 12:02 AM. She stated that they were really short staffed on Saturday 4/15/17 and she worked first shift. She stated that none of the residents were given a shower on Saturday on blue hall. She had teamed up with the other NAs to get bed baths done with all other residents because there wasn't enough staff. She stated she worked 16 hours that day.

The resident was interviewed on 4/22/17 at 1:49 PM. He stated he really wanted a shower last Saturday, 4/15/17. He stated he really wanted a shower but he stated it didn't happen because there was not enough staff.
Nurse #5 was interviewed on 4/22/17 at 11:36 AM. She stated that she worked last Saturday 4/15/17 and Sunday 4/16/17 and the Nursing Assistants were short staffed. She stated the nursing assistants got to everyone to provide care the best they could. She stated that she suspected that some showers were missed, but was not told of any that did not get completed. She stated they were really short staffed on the blue hall and the on call nurse never came in.
The administrator was interviewed on 4/22/17 at 6:22 PM. He stated that he would expect for staff for take care of the residents' needs. He stated the staffing over the Easter holiday weekend was rough and they were short staffed with Nursing Assistants. He stated they had multiple staff members that called out over Easter the weekend. He stated the staffing was usually alright minus this past weekend.

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2.) Resident #24 was admitted to the facility on 10/27/2003 with the current diagnosis of heart failure, Hemiplegia, and multiple falls.

Resident #24's Minimum Data Set dated 4/2/17 revealed the resident was moderately cognitively intact and required total dependence for bathing.

The resident had a care plan in place last updated 4/7/17 for Activities of Daily Living Deficit due to left sided hemiparesis.
Review of the resident's Activities of Daily Living flow sheet and the shower assignment sheets revealed the resident did not receive a shower or any kind of bath on Saturday 4/15/17.

There were no notes that revealed the resident got a shower or bath of any kind on 4/15/17.

Resident #24 was interviewed on 4/21/17 at 4:13 PM. She stated on Saturday that she was supposed to get a shower in the afternoon. The NA told her that they didn't have enough staff to help to get her to the shower. She stated she told the NA she was ok not getting a shower since she knew they didn't have enough staff. She stated she usually got a shower twice a week on Wednesday and Saturdays.

NA #7 was interviewed on 4/22/17 10:05 AM. She stated that the resident #24 had changed rooms. She stated that when the resident's room was changed her shower days stayed the same so the resident's shower days were Wednesday and Saturday and that the shower schedule did not reflect this change but they all knew that it was Wednesday and Saturday.
Nurse #5 was interviewed on 4/22/17 at 11:36

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AM. She stated that she worked last Saturday 4/15/17 and Sunday 4/16/17 and the Nursing Assistants were short staffed. She stated the nursing assistants got to everyone the best they could. She stated that she suspected that some showers were missed, but was not told of any that did not get completed. She stated they were really short staffed on the blue hall and the on call nurse never came in.

NA # 5 was interviewed on 4/22/17at 12:02 AM. She stated the resident got showers on Saturdays. She stated that they were really short staffed on Saturday and resident #24 did not get a shower but got washed up in the bathroom. The resident was able to help some. She stated she offered to give the resident a shower after but the resident stated "they don't have to give me a shower because I know you all are short staffed today". She stated she counted that as the resident refusing a shower. She stated that none of the residents were given a shower on Saturday on blue hall. She had teamed up with the other NAs to get bed baths done with all other residents because there wasn't enough staff. She stated she worked 16 hours that day.

The administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated he would expect for staff for take care of the residents' needs. He stated the staffing over the Easter holiday weekend was rough and they were short staffed of Nursing Assistants. He stated they had multiple staff members that called out over Easter weekend. He stated the staffing was usually alright minus this past weekend.

3.) Resident #97 was admitted on 7/8/16 with the current diagnoses of heart failure, diabetes and

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hypertension.
The resident's MDS dated 3/3/17 revealed she was moderately cognitively intact. The resident required extensive assistance with bed mobility, transfers, locomotion, dressing, eating, toilet use and personal hygiene. The resident got intermittent catheterization. She had urinary continence and was frequently incontinent of bowel.

The resident had care plans last updated 3/8/17 for Activities of Daily Living and refusal of care.

Resident #97 was up to her wheel chair in her room on 4/20/17 at 10:17 PM. The resident stated that she had been waiting to use the bedpan and had been waiting an hour. She stated she asked staff before 9:00 PM to get her to the bathroom and bed but was still waiting. She stated she always used the bedpan or bathroom. On observation, the resident's voice was whiney and desperate. The resident appeared to be holding back from crying and was moving around in her wheelchair as if she was uncomfortable. The resident still had her day clothes on.

On 4/20/17 at 10:28 PM, the resident was still waiting in the wheelchair in her room for staff.

On 4/20/17 at 10:45 PM, the resident was transferred from the wheelchair to her bed with the assistance of 2 staff members via the lift. When the NA went to get the bedpan out of the bathroom the resident started to scream "hurry, hurry, I have to go". The resident was place on the bedpan and urinated. The resident was cleaned, changed into her pajamas and repositioned in bed.

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SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

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NA #6 was interviewed on 4/20/17 at 11:12 PM. She stated the resident sometimes used the toilet but mostly used the bedpan. She stated the resident always needed assistance from 2 people with the lift and she was rarely incontinent. She stated she always had to find someone to help her with the resident. She stated that tonight at 8:30 PM, the resident told her she wanted to get to bed and she told the resident it was going to be a while because she had other people to see and a new admit and then would get back to her. She stated the resident always the bedpan before getting to the bed.
Nursing Assistant #8 was interviewed on 4/20/17 at 11:12 PM. She stated the administration was putting extra people on the schedule that were not actually here. She stated that staffing had been terrible for 3 months.

The resident's family member were interviewed on 4/22/17 at 12:41 PM. The resident's family member stated that the resident told him that she had to wait an hour sometimes for them to answer the call bell. He stated the resident had told him that it happened again last night and she had to wait a long time to use the bed pan and then had to wait a long time for the staff to take her off of the bed pan. He stated he knew they are under-staffed and the resident has had an accident in the past because they could not get her the bedpan in time.

The resident was interviewed again on 4/22/17 at 12:41 PM. She stated that she had to wait last night on 4/21/17 too. That on Thursday night, 4/20/17, she had used her call bell to call before 9:00 PM and that the staff never came. She stated the staff were ignoring her and that made her feel mad.

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F 353	Continued From page 103 The administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated that he would expect staff to take care of the residents' needs. He stated the staffing over the Easter holiday weekend was rough and they were short staffed of Nursing Assistants. He stated they had multiple staff members that called out over Easter weekend. He stated the staffing was usually alright minus this past weekend.	F 353		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		6/5/17

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F 371	Continued From page 104	F 371	F371:	

by:
Based on observations and staff interviews the facility failed to ensure cookware and service ware were clean, air dried and in good repair; kitchen equipment, walls and ceiling tiles were clean and in good repair; and food was labeled, dated and stored in sealed packages. This had the potential to impact 83 of the 85 residents that resided in the facility.

Findings Included:

An observation of the kitchen on 4/18/17 at 10:50 am with the Dietary Manager identified:

· 5 of 5 steam table pans were on a storage shelf stacked together wet with food particles.

· 25 of 25 meal trays were on a storage cart stacked together wet with food particles, pieces of tape and exposed metal edges.

· 23 ceiling tiles had stains and food substances on them.

· A section (approximately 15" long and 12" wide) of the wall under the hood system was damaged with peeling paint. The hood vents and light covers under the hood system had a coating of grease and dust on them.

The table that held the steamer was covered with rusty colored water that contained food particles.

· There was a black substance on the seal of the ice machine bin door.

· A storage bin that contained packages of

A. The steam table pans were thoroughly cleaned and allowed to air dry by the dietary staff member on 4/18/17. Meal trays were reviewed by the Dietary Manager 4/18/17. Those identified with exposed metal edges were discarded. The remaining meal trays were thoroughly cleaned and allowed to air dry prior to returning them to service. New meal trays were ordered to replace those that were discarded. Ceiling tiles were reviewed by the Maintenance Director and Maintenance Assistant on 4/25/17. Those that needed replacement were replaced. The others were cleaned to remove food particles. The identified section of wall under the hood system with damage and peeling paint repairs and repainting will be completed by the Maintenance Assistant on 4/24/17. The hood vents and light covers under the hood system were thoroughly cleaned by the Chef on 4/18/17. The table that holds the steamer was thoroughly cleaned by the dietary staff member on 4/18/17. The seal of the ice machine bin door was cleaned thoroughly by the Dietary Manager on 4/18/17. The storage bin that contained gelatin mix that was stained and contained food particles was washed and air dried by the Chef. The metal cart containing cans of food was cleaned thoroughly by dietary staff member on 4/18/17. The opened bags of diced ham, chicken pieces, veggie burgers that were not labeled or dated and the open case of

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F 371	Continued From page 105 gelatin mix was stained and contained food particles. A metal cart containing cans of food had a layer of dust and food particles on it. · The walk-in freezer contained opened bags of diced ham, chicken pieces and veggie burgers that were not labeled or dated. An open case of okra and an open case of succotash were not in sealed containers and exposed to the air. An interview on 4/22/17 at 12:43 pm with the Dietary Manager revealed she expected the steam table pans to be clean and air dried on drying mats before they were put away. She stated that the meal trays with exposed metal edges should be replaced and the adhesive tape should be removed. She expected the meal trays to be clean and allowed to air dry. She stated that the damaged ceiling tiles should be replaced and the ceiling should be clean and without food splatters. She stated the wall under the vent system should be repaired and the hood vents and light fixtures should be cleaned routinely. She expected when the staff saw something dirty or spilled they should clean it immediately. She stated that all open food products should be resealed, labeled and dated. An interview with the Administrator on 4/22/17 at 2:05 pm revealed he expected all open food items would be sealed, labeled and dated. He expected all of the kitchen equipment, walls and ceiling to be clean and in good repair. He stated dishware should be in good repair, clean and allowed to air dry.	F 371	succotash that was not in sealed containers were discarded by the Dietary Manager on 4/18/17. B. An inspection of the kitchen was completed by the Dietary Manager on 4/18/17 and any other issues identified were addressed by the Dietary Manager on 4/18/17. C. Education will be completed by the Dietary Manager with Dietary Staff by 4/23/17 regarding maintaining a sanitary environment in the kitchen and the requirements of F371. Routine cleaning schedules were developed by the Dietary Manager and reviewed with Dietary Staff by 4/23/17. Routine Maintenance rounds in the kitchen were developed by the Administrator on 5/17/17 and reviewed with Maintenance Staff. Routine maintenance rounds will be conducted monthly by the Plant Operations Manager or Plant Operations Assistant. Dietary staff will document maintenance items for repair on the Maintenance repair log for review by the Plant Ops Director as repairs arise. D. The Dietary Manager will complete a daily review of the daily cleaning schedule as well as weekly rounds by the Dietary Manager, Assistant Dietary Manager, Regional Dietary Manager or Administrator. This review will be documented on the daily cleaning schedule for four weeks, then monthly for two months. A Review of monthly maintenance rounds by Plant Operations Manager or Plant Operations Assistant will be documented monthly x 3 months. All	

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F 371	Continued From page 106	F 371	data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the Dietary Manager and Plant Operations Manager. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Services.	
F 372 SS=C	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep the door of 1 dumpster (1 of 2) closed and maintain the ground around the dumpster free of trash. Findings included: An observation of the dumpster area with the Dietary Manager on 4/18/17 at 11:15 am revealed the door of 1 dumpster was open and a bag of trash was hanging out of the door. Cardboard, plastic gloves, a tube of toothpaste, soda bottles and snack wrappers were noted to be on the ground around the dumpsters. An interview with the Dietary Manager on 4/22/17 at 12:43 pm revealed she expected the dumpster door to be closed and that there would be no trash on the ground.	F 372	F372: A. No specific residents were identified in this cite. The dumpster door was closed by the Dietary Manager upon identification of the concern. The bag of trash was placed inside the dumpster and the area around the dumpster was cleared of trash and debris. B. All residents have the potential to be affected by the alleged deficient practice. The dumpster door was closed by the Dietary Manager upon identification of the concern. The bag of trash was placed inside the dumpster and the area around the dumpster was cleared of trash and debris. C. Education was provided by the Maintenance Director, Staff Development Coordinator, or Director of Nursing to	5/31/17

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F 372	Continued From page 107 An interview with the Administrator on 4/22/17 at 2:05 pm revealed his expectation was that the dumpster area would be clean and the dumpster door would be closed.	F 372	facility staff to include nursing staff, dietary staff, and housekeeping staff, regarding the requirement to keep the dumpster door closed and keep the area around the dumpster clear of trash and debris. This will be completed by 5/31/17. D. The Maintenance Director or Maintenance Assistant will complete rounds 2 times daily for 2 weeks, 3 times weekly for 2 weeks, then weekly for 2 weeks to ensure the dumpster door remains closed and that the area around the dumpster is clear of trash and debris. Findings of the rounds will be forwarded to the Administrator to ensure corrective actions immediately upon identification of any concern. Findings of the rounds will be discussed by the Maintenance Director with the Quality Assurance Performance Improvement team (QAPI) monthly for 3 months for recommendations and further follow-up as indicated.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		5/31/17

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F 431	Continued From page 108 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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. This REQUIREMENT is not met as evidenced by:	F 431		

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F 431	Continued From page 109 Based on observations and staff interviews, the facility: 1) Failed to discard expired medications or medications with shortened expiration dates in 1 of 2 medication rooms (Red Hall medication room) and on 2 of 4 medication carts (Blue Hall back cart and Blue Hall front cart); and, 2) Failed to store medications in accordance with the manufacturer's recommendations in 1 of 2 medication rooms (Red Hall medication room) and on 1 of 4 medication carts (Red Hall front cart). 1.a. Accompanied by the facility ' s Corporate Nurse Consultant, an observation was made on 4/19/17 at 2:30 PM of the Red Hall medication room. The observation revealed an open, vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis) was stored in the refrigerator. A hand-written date was written both on the outside of the box and on the vial itself to indicate the Tuberculin PPD medication was opened on 1/21/17. A pharmacy auxiliary sticker placed on the vial read, "Discard unused portion after the expiration date of 30 days." The manufacturer ' s product information indicated opened vials of Tuberculin PPD injectable medication should be discarded after 30 days. An interview was conducted on 4/19/17 at 2:35 PM with the facility ' s Corporate Nurse Consultant. Upon inquiry, the Nurse Consultant confirmed the Tuberculin PPD medication was expired. An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the	F 431	F431: A. The Tuberculin PPD injectable medication that had an opened date of 1/21/17 was discarded on 4/19/17 by the Nurse Consultant. The Lantus Insulin with an opened date of 3/9/17 was discarded on 4/19/17 by the Charge Nurse. The Budesonide Inhalation Suspension for Resident #43 that was found to be open and not dated to indicate when it had been opened was discarded by the Charge Nurse on 4/19/17. The Budesonide Inhalation Suspension for Resident #28 that was found to be open and not dated to indicate when it had been opened was discarded by the Unit Manager on 4/19/17. The Niacin 500mg tablets (stock medication) that were found to be expired were discarded by the Nurse Consultant on 4/19/17. The Prednisolone Acetate 1% ophthalmic solution that was found to be stored inappropriately was discarded by the Corporate Nurse on 4/19/17. The Dorzolamide-timolol eye drops that were inappropriately stored in the refrigerator were discarded by the Nurse Consultant on 4/19/17. B. All residents have the potential to be affected by the alleged deficient practice. An audit of medication carts was audited by the nurse consultant on 4/19/17 any concerns identified were immediately corrected. C. Education will be completed by the staff development coordinator by 5/31/17 regarding F431 and the policy for labeling and storage of drugs and biologicals for licensed nursing staff. A review was completed of all medication carts and	

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F 431	Continued From page 110 interview, the Administrator reported he had been made aware of the medication storage concerns identified on 4/19/17. He stated, "That was unacceptable." 1.b. An observation was made on 4/19/17 at 3:15 PM of the Blue Hall back medication cart. The observation revealed an opened vial of Lantus insulin stored on the medication cart was expired. The Lantus insulin was labeled for use by Resident #97. A handwritten note on the insulin vial itself indicated the insulin was opened on "3/9". The manufacturer ' s product information indicated once punctured (in use), Lantus insulin vials may be stored under refrigeration or at room temperature for up to 28 days. A review of Resident #97 ' s Physician Orders revealed there was a current order for Lantus insulin to be given as 14 Units injected subcutaneously (under the skin) once daily every night at bedtime. Information provided by Resident #97 ' s April 2017 Medication Administration Record (MAR) indicated the resident received a dose of Lantus insulin 11 times after the insulin ' s calculated expiration date of 4/6/17. An interview was conducted with Unit Manager #1 on 4/19/17 at 3:20 PM. During the interview, the Unit Manager acknowledged Lantus insulin should be discarded within 28 days after opening. An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns	F 431	medication rooms on 4/20/17 by the Director of Nursing, Assistant Director of Nursing, or Unit Coordinator, Licensed Nurse or Nurse Consultant to ensure that no other expired medications were available for usage, that multi-dose vials were appropriately labeled and dated as to when they were opened, and that medications were stored appropriately based upon manufacturer□s guidelines. No other concerns were identified. D. The Director of Nursing, Assistant Director of Nursing, Unit Coordinator, Licensed Nurse or Nurse Consultant will complete an audit 3 times a week for 2 weeks, then 2 times weekly for 2 weeks, then once weekly for 2 weeks of medication rooms and medication carts to ensure medications are labeled appropriately, that medications are not expired and available for use, and are stored according to manufacturer□s guidelines. Corrective action will be completed immediately upon identification of a concern. Findings of the above stated audit will be discussed by the Director of Nursing with the Quality Assurance Performance Improvement Committee (QAPI) monthly for 6 months to ensure continued compliance and for recommendations and further follow-up as indicated.	

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F 431	Continued From page 111	F 431		

identified on 4/19/17. He stated, "That was unacceptable."

1.c. Accompanied by Unit Manager #1, an observation was made on 4/19/17 at 3:15 PM of the Blue Hall back medication cart. The observation revealed a carton of 0.5 mg / 2 ml budesonide inhalation suspension (a corticosteroid medication to be inhaled via use of a nebulizer) labeled for Resident #43 was stored in a drawer of the medication cart. Labeling on the carton of the budesonide inhalation suspension indicated the medication was dispensed from the pharmacy on 3/28/17. The carton included one opened and empty foil envelope lying in the box on top of 1 vial of inhalation suspension lying on the bottom of the carton. Upon review, the manufacturer labeling on the box of the budesonide inhalation suspension included storage instructions which read, in part: "Once the foil envelope is opened, use the vials within 2 weeks." The foil envelope was not dated to indicate when it had been opened.

A review of Resident #43 ' s Physician Orders revealed there was a current order for budesonide 0.5 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily.

An interview was conducted with Unit Manager #1 on 4/19/17 at 3:20 PM. During the interview, the Unit Manager reported she did not know when the foil envelopes had been opened.

An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns

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identified on 4/19/17. He stated, "That was unacceptable."

1.d. Accompanied by Unit Manager #1, an observation was made on 4/19/17 at 3:05 PM of the Blue Hall front medication cart. The observation revealed a carton of 0.5 mg / 2 ml budesonide inhalation suspension (a corticosteroid medication to be inhaled via use of a nebulizer) labeled for Resident #28 was stored in a drawer of the medication cart. Labeling on the carton of the budesonide inhalation suspension indicated the medication was dispensed from the pharmacy on 4/3/17. The carton included one opened foil envelope containing 3 vials of inhalation suspension; and, a second opened foil envelope containing 2 vials of inhalation suspension. Upon review, the manufacturer labeling on the box of the budesonide inhalation suspension included storage instructions which read, in part: "Once the foil envelope is opened, use the vials within 2 weeks." Neither of the opened foil envelopes were dated to indicate when they were opened.

A review of Resident #28 ' s Physician Orders revealed there was a current order for budesonide 0.5 mg / 2 ml inhalation suspension to be given as one vial via nebulizer twice daily.

An interview was conducted with Unit Manager #1 on 4/19/17 at 3:10 PM. During the interview, the Unit Manager reported she did not know when the foil envelopes had been opened.

An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns

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identified on 4/19/17. He stated, "That was unacceptable."

1.e. Accompanied by the facility ' s Corporate Nurse Consultant, an observation was made on 4/19/17 at 2:30 PM of the Red Hall medication room. The observation revealed an unopened stock bottle of 500 milligrams (mg) Niacin tablets (a vitamin B supplement) was stored on the shelf with the other stock medications. The manufacturer ' s expiration date stamped on the bottle was January 2017.

An interview was conducted on 4/19/17 at 2:35 PM with the facility ' s Corporate Nurse Consultant. Upon inquiry, the Nurse Consultant confirmed the stock bottle of 500 mg Niacin tablets was expired.

An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns identified on 4/19/17. He stated, "That was unacceptable."

2.a. Accompanied by the facility ' s Corporate Nurse Consultant, an observation was made on 4/19/17 at 2:45 PM of the Red Hall front medication cart. The observation revealed an opened bottle of prednisolone acetate 1% ophthalmic suspension eye drops (a steroid medication) was stored lying down on its side in a drawer of the medication cart. The eye drops were labeled for use by Resident #76 and dispensed from the pharmacy on 3/24/17 (opened on 3/26/17). The manufacturer ' s storage instructions printed on the label of the eye drops read in capital letters, "STORE UPRIGHT"

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at 8o-24oC (46o-75oF).

A review of Resident #76 ' s physician orders revealed the resident had a current medication order for prednisolone acetate 1% ophthalmic suspension eye drops to be given as one drop instilled into the right eye three times a day.

An interview was conducted on 4/19/17 at 2:50 PM with the facility ' s Corporate Nurse Consultant. Upon inquiry, the Nurse Consultant reported the prednisolone acetate eye drops would need to be stored upright in accordance with the manufacturer ' s instructions.

An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns identified on 4/19/17. He stated, "That was unacceptable."

2.b. Accompanied by the facility ' s Corporate Nurse Consultant, an observation was made on 4/19/17 at 2:30 PM of the Red Hall medication room. The observation revealed an unopened bottle of dorzolamide-timolol eye drops (a combination eye medication used to treat glaucoma) was stored in the refrigerator. The temperature of the medication room refrigerator was noted to be 42o F at the time of the observation. The eye drops were labeled for use by Resident #9 and dispensed from the pharmacy on 3/27/17. The manufacturer ' s storage instructions specified in the package insert indicated the eye drops should be stored at 20o-25oC (68o-77oF).

A review of Resident #9 ' s physician orders

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F 431	Continued From page 115 revealed the resident had a current medication order for dorzolamide-timolol eye drops to be given as one drop instilled into each eye two times a day. An interview was conducted on 4/19/17 at 2:35 PM with the facility ' s Corporate Nurse Consultant. Upon inquiry, the Nurse Consultant reported she would need to check with the pharmacy to see if the medication could still be used. The Consultant stated she would expect medications to be stored in accordance with the manufacturer ' s instructions. An interview was conducted on 4/20/17 at 5:15 PM with the facility ' s Administrator. During the interview, the Administrator reported he had been made aware of the medication storage concerns identified on 4/19/17. He stated, "That was unacceptable."	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		5/31/17

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(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective

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F 441	Continued From page 117 actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document surveillance of a room and surrounding rooms and residents after the discovery of bed bugs, and failed to prevent the spread of bed bugs to additional resident rooms for 4 of 24 sampled residents reviewed for pest control (resident #67, resident #48, resident #173 and resident #25). Findings included: The facility's bed bug policy dated 8/2015 stated the effective treatment of bed bugs included staff and resident education, recordkeeping and reporting, treatment of resident's symptoms, treatment of infestation and evaluation of treatment effectiveness and continued monitoring. The policy also specified that the facility should document the actions taken for the reported infestation, staff training on eradication measures, and a facility wide plan to monitor and respond to future infestations. A nursing note dated 11/24/16 stated that a nursing assistant was giving care to Resident #48 when she noticed some bed bugs on the resident. The Nursing Assistant took some specimens on tape and asked another staff member to confirm	F 441	F441 A. On 3/15/17 rooms 110 and 111 were inspected and there was no noted bed bug activity during this inspection. Bed bugs were addressed for residents #25, #48, #67, #173 through skin evaluations and there is no further indication or observation of active bed bugs. B. All residents have the potential to be affected by this alleged deficient practice. An inspection on 5/18/17 by the pest management company revealed no bed bugs. C. Education was provided to Licensed Nursing and Certified Nursing Assistants by Staff Development Coordinator, Director of Nursing, and Plant Operations Manager regarding surveillance of staff members that come in contact with residents that are found to have bed bug. Maintaining documentation of surveillance that is completed on other residents to monitor for future bed bugs. The policy and procedure for pest control (bed bug). D. The pest management company will	

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F 441	Continued From page 118 the bed bugs. The supervisor was called and advised that the resident be moved to room 110B and that a skin check be completed. Another nursing note dated 11/24/16 stated that Resident #67 who was the roommate of Resident #48, was also moved to another room since bed bugs were found in Resident #48 bed. Both residents were showered and dressed in a facility gown. A nursing note dated 11/25/16 stated that a skin check was performed on resident #67. There were no signs or symptoms of bites or complaints of itching. The resident agreed with daily skin checks and mattress checks. There were no further treatments or orders at this time. There was no other documentation provided about the surveillance of staff members that came in contact with Residents #67 and #48 on 11/24/16. An email dated 11/30/17 stated that pest control confirmed the bed bugs were present in the room, where Residents # 67 and # 48 had resided on 11/25/16. Review of the November, 2016 Medication Administration Record (MAR) revealed Resident # 48 was not placed on isolation until 11/25/16. The November, 2016 MAR revealed that Resident #48 was placed on contact isolation for bed bug from 11/25/16 through 11/28/16 and mattress checks were completed from 11/25/16 through 11/30/16. A note from pest control dated 11/26/16 revealed that bed bugs were noted during inspection of	F 441	audit and document surveillance of room 110, 111 periodically and other rooms within the facility monthly x 6 months. Any issues or trends identified will be addressed by the Quality Assurance Committee (QAPI) as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Services. This will be completed by 5/31/17.	

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room 111, where Residents #67 and #48 resided. Bed begs were noted during treatment. Bed bug activity was present only in room 111 bed A and the wheelchair. The action needed stated that the room was inspected and serviced and should be taken out of service until further notice. Rooms 110, 112, and 113 were also treated for bed bugs and inspected but no bed bugs were noted.

A 24 hours follow up from pest control dated 11/27/16 stated that no bed bug activity was noted in room 111 on follow up after treatment. Rooms 112, 114, 110 were also inspected and no bed beg activity was found. A follow up treatment was completed for room 111 and no activity was found on the second follow up.

A staff in-service dated 11/30/16 revealed staff was educated on facility's bed bug policy.

There was no documentation of surveillance that was completed for other residents or a plan implemented to monitor for future bed bug infestations from 11/27/16 to 12/9/16.

The infection control (IC) nurse was interviewed on 4/21/17 at 2:08 PM. She stated the facility had problems with bed bugs in November, December and January. She stated in November, 2016, bed 111A was affected that both residents who resided in this room were showered, moved to different rooms, given new wheelchairs, and pest control was called. They thought that a family member had brought in the bed bugs. All other residents were assessed and bed and resident skin checks were preformed every shift. The IC nurse explained another issue with bed bug issue happened in December, 2016 for rooms 110 A (resident #173) and the same protocol was

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initiated and the resident was given a new wheelchair. Pest control came out again to treat the room 110 A on 12/20/16. Resident #173 was moved to another rooms and was placed on isolation. Then one month later in January, 2017 rooms 110 and 111 had bed bugs and pest control stated they were adult male bugs only. The same bed bug protocol was followed again. Pest control had been coming every month to assess the building. There has not been any concern since with bed bugs. The IC nurse stated that she did not bring the bed bug issue to the Quality Assurance committee.

The infection control nurse was interviewed again on 4/21/17 at 3:10 PM. She stated she only had the documented surveillance for bed bugs for Jan, 2017 and did not have the surveillance for November and December, 2016 because in November, 2016 the pest control had found the bed bugs on their inspection. She stated the corporate office had given her a check list of what to do for bed bugs in December, 2016 that she completed it.

The pest control staff was interviewed 4/21/17 at 3:56 PM. He stated that he completed a monthly service at the facility. He typically checked traps, bates and sprays in the kitchen and would check residents room only if the facility asked. He stated bed bugs were found 3 times in November, December and January at the facility and in January, 2017 he did the treatment. He stated that a 3 step process was followed, then a 24 hour service was completed and 2 week follow up was completed. Initially, they treated the infected room and sometimes the adjoining rooms. He stated 1/30/17 that he treated room 110 and the room beside it. He stated he also sprayed the

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medical office too. He stated that he would always spray the adjoining rooms too. He stated the pest control staff had the facility bag up everything in the resident's room, wash everything at the hottest temperature as possible and then separate and clean everything before the resident was let back in the room. The resident's wheelchair were to be cleaned using an alcohol based solution. They were not sure how the bed bugs were coming in but thought family was bringing them in.

The Infection control nurse was interviewed on 4/22/17 at 5:07 PM. She stated the facility did surveillance of bed bugs for the entire facility via the nurses but didn't know where they documented it for the first and second time they had incidents of bed bugs.

The Infection control nurse was interviewed on 4/22/17 at 1:52 PM. She stated there was no other paperwork she had on what was done about the bed bugs. She didn't know where the surveillance for bed bugs was for the missing months, the nurses were supposed to be doing the checks for the blue hall, which was where the bed bugs were found.
The administrator was interviewed stated on 4/22/17 at 6:22 PM. He stated he would expect for pest control to be called to make sure the bed bugs were gone.

A pest control note dated 12/20/16 stated that bed bugs were noted during inspection in room 110 and they recommended that the room be taken out of service.

A nursing note dated 12/22/16 stated Resident #173 was moved from room #110 to room #114

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due to bed bug problems and placed on isolation precautions.

A quality assessment (QA) and improvement report dated 12/2016 for bed bugs was completed and check list of 17 items that were completed. This included that block and random audits of residents body and mattresses were completed (no date). The health department was notified (12/22/16), employees were interviewed (12/20/16), pest control was contacted for cleaning rooms and other surfaces (12/21/16), affected resident and roommate's clothes were disinfected and bagged per pest control (12/20/16) per CDC guideline and pest control and body audit was performed on affected resident (12/20/16), affected residents were treated (12/22/16), facility wide skin sweeps were performed weekly for 1 month and monthly for 3 months (per skin schedule.)

The MAR for Resident #173, who originally resided in room #110, revealed the resident was on contact isolation from 12/22/17 through 12/29/16 and was getting mattress and skin checks from 12/22/16 through 12/29/16.

A pest control note dated 12/23/16 stated that room 110 was inspected and treated for bed bugs. Rooms 111,113,114, 119 were also inspected and no bed bug activity was found. The note also stated that during the inspection that bed bugs were on the wheelchair of room 110 and treatment was also completed on the exterior courtyard.

There were no documentation of other resident's rooms that were checked for bug surveillance completed for hall 100 or the facility for

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December, 2016.

Another note from pest control revealed on 1/13/17 bed bugs were noted during inspection in room 110 on the recliner and on the bed closest to the door. The note stated this was a "bed bug inspection only provided" and recommend that rooms be taken out of service.

An email dated 1/13/17 to the corporate consultant revealed that 2 bed bugs were found on 110A and ECO lab feels they are not breeding here in house as there were no evidence of baby bed bugs in 110 or 111, the rooms were inspected as part of our performance improvement. Both residents in room 110 were showered and moved to another room. Nursing would perform skin checks and room checks on the surrounding rooms.

Another note from pest control dated 1/16/16 stated that bed bugs were noted during treatment in room 110. Rooms 110, 111 and medical office records were also inspected and treated.

A pest control note dated 1/17/17 revealed there were no bed bugs noted on inspection of room 110 and that they came monthly to the facility for inspections.

A nursing note dated 1/17/17 revealed the resident #25 was moved back to her old room and no issues were noted prior to the move.

The MAR for Resident #25, who originally resided in room 110, revealed daily skin checks and mattress checks were completed on 1/13/17 through 1/18/17 and Resident #25 was on isolation from 1/1/17 through 1/19/17.

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F 441	Continued From page 124 An insect/bed bug skin check was completed on 1/22/17 for all residents on 100 hall on the 11:00 AM- 7:00 AM shift, 7:00 AM - 3:00 PM shift and 3:00 PM to 11:00 PM shift and 7:00 AM - 11:00 PM shift and no bed bugs were noted.	F 441		