STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328

(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 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 promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to ensure a privacy bag was utilized for 3 of 3 residents with a urinary catheter (Resident #12, Resident #218 and Resident #87). Findings included: 1. Resident #12 was originally admitted to the facility on 06/19/13 with diagnoses which included retention of urine and hydronephrosis. She was re-admitted to the facility on 08/08/17 with the diagnosis of Urinary Tract Infection (UTI). A review of Resident #12's annual Minimum Data Set (MDS), dated 07/01/17, revealed Resident #12 was severely cognitively impaired and required the extensive assistance of staff for bed mobility, toileting and personal hygiene. The MDS indicated Resident #12 had an indwelling urinary catheter. A review of Resident #12's Care Area Assessment (CAA), dated 07/01/17, indicated Resident #12 had an indwelling urinary catheter due to hydronephrosis of her right kidney and was under the care of a urologist. A review of Resident #12's Care Plan, last	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 241 Corrective Action for Resident Affected Residents #12, # 218 and # 87 had their urinary catheter bags immediately covered for privacy on 8/16/17 by licensed nurses. Corrective Action for Resident Potentially Affected	9/15/17

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

Electronically Signed | 09/08/2017

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F 241	Continued From page 1 updated 06/30/17, indicated Resident #12's urine catheter bag should be kept adequately covered to promote her dignity. During an observation of Resident #12 on 08/16/17 at 9:47 a.m., Resident #12 was lying in her bed. The urine collection bag of her indwelling urinary catheter hung on the side of her bed with the clear side of the bag facing the entrance to the room. The urine collection bag did not have a privacy flap or a cloth cover. During an interview with Nurse #3 on 08/17/17 at 2:10 p.m., Nurse #3 stated Resident #12 returned to the facility on 08/08/17 at 6:37 p.m. after having been at the hospital for a UTI. Nurse #3 stated she assessed Resident #12 and completed the admission process. Nurse #3 stated she recalled looking at the urine in the collection bag. Nurse #3 stated it was the end of her shift and she was wrapping things up and stated she probably just forgot to replace the urine collection bag with one that has a flap on it. During an interview with the Director of Nursing (DON) on 08/16/17 at 12:56 p.m., the DON stated it was her expectation nursing staff have a dignity bag in place for all residents with indwelling urinary catheters. 2. Resident #218 was admitted to the facility on 07/21/17 with diagnoses which included benign prostatic hypertrophy (BPH), chronic kidney disease and urinary tract infection (UTI). A review of Resident #218's Admission Minimum Data Set (MDS), dated 07/28/17, revealed Resident #218 was severely cognitively impaired and required the extensive assistance of staff for	F 241	On 8/16/17 licensed nurses assessed 18 current residents with urinary catheters to ensure they had privacy covered drainage bags. 3 out of 18 were found to not have covered urinary catheter bags. On 8/16/17, 3 urinary catheters were covered with privacy covers by licensed nurses. Systemic Changes On 8/16/17 the Director of Nursing and Staff Development Coordinator initiated in servicing FT, PT and PRN nurses, nursing assistants, medication aides and medication techs on the following: ¿ All urinary catheter drainage bags must be covered for resident privacy in skilled facilities ¿ When residents are admitted or readmitted it is important to assess the urinary drainage bags to ensure that a privacy cover is on the urinary drainage bag ¿ Nursing Assistants, Med Techs and Med Aides educated on why urinary drainage bags are to be covered for privacy and to report if they identify any uncovered urinary drainage bags ¿ All clinical staff were educated where the privacy urinary drainage bag covers are located Any staff not receiving the education, will not be permitted to work until receiving	

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F 241	Continued From page 2 bed mobility, toileting and personal hygiene. The MDS indicated Resident #218 had an indwelling urinary catheter, BPH, UTI and renal insufficiency. The MDS indicated Resident #218 used a walker or wheelchair for mobility. A review of Resident #218's Care Area Assessment (CAA), dated 07/28/17, indicated Resident #218 was originally admitted to the facility on 07/13/17. He was re-admitted to the facility on 07/21/17 after a hospitalization for UTI and severe sepsis. The CAA indicated Resident #218 had an indwelling urinary catheter due to urine retention. A review of Resident #218's Care Plan, last updated on 08/16/17, indicated Resident #218's urinary catheter bag should be kept adequately covered to promote his dignity. During an observation of Resident #218 on 08/15/17 at 10:42 a.m., Resident #218 was sitting in an armchair in his room with his walker placed near his chair. Resident #218's urine collection bag was attached to his walker with no privacy flap or cloth cover. The clear side of the urine collection bag was visible upon entrance to the room. During an interview with Nurse #4 on 08/18/17 at 2:38 p.m., Nurse #4 stated when Resident #218 returned to the facility on 07/21/17, he returned with an indwelling urinary catheter. Nurse #4 stated she recalled checking the size of the urinary catheter and the color of his urine but stated she honestly did not think about changing the urine collection bag. Nurse #4 stated she was an "old-school" nurse and she was taught not to open the line unless it was necessary. Nurse	F 241	the education by September 15, 2017. Quality Assurance The Staff Development Coordinator/Licensed Nurse will monitor using the QA Catheter Audit Tool to ensure all urinary catheter drainage bags are covered for privacy by assessing five residents weekly. This audit will be performed weekly for four weeks, then monthly for 2 months, including weekends. Reports will be presented to the weekly QA committee by the Administrator/Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Unit Manager, Support Nurse, Rehab Director, HIM, Dietary Manager and the Administrator. Compliance date: September 15, 2017	

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#4 stated she briefly thought of the cloth bag it could be placed in but stated she just overlooked it.

During an interview with the Director of Nursing (DON) on 08/16/17 at 12:56 p.m., the DON stated it was her expectation nursing staff have a dignity bag in place for all residents with indwelling urinary catheters.

3. Resident #87 was admitted to the facility on 7/20/17 with diagnoses which included Chronic Kidney Disease, Atrial Fibrillation, Irritable Bowel Syndrome, Hypertension and Diabetes.

A review of Resident #87 Admission Minimum Data Set (MDS), dated 7/27/17, revealed Resident #87 was severely cognitively impaired and was totally dependent of staff for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #87 was always incontinent for bowel and bladder.

A review of Resident #87 ' s Care Area Assessment (CAA), dated 7/27/17, indicated Resident #87 was originally admitted to the facility on 7/20/17. Resident #87 was re-admitted to the facility on 8/1/17 after a hospitalization and returned to the facility with an indwelling catheter for comfort care related to a terminal illness.

A review of Resident #87 ' s Care Plan, last updated 8/16/17, indicated Resident #87 ' s urinary catheter bag should be covered adequately to promote dignity.

During an observation of Resident #87 on 8/14/17 at 2:30 p.m., Resident #87 was lying in bed. The urine collection bag hung on the side of the bed with the clear side of the bag facing the entrance

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F 241	Continued From page 4 to the room. The urine collection bag did not have a privacy flap or a cloth cover. During an interview with Nurse #7 on 8/17/17 at 2:31 p.m., Nurse #7 stated when Resident #87 returned to the facility on 8/1/17, she returned with an indwelling urinary catheter. Nurse #7 stated she recalled checking the urinary catheter size, color of urine in the bag, amount of urine in the bag, but she did not think about covering the bag or changing the bag because the bags from the hospital were different from the facility ' s bag. During an interview with the Director of Nursing (DON) on 8/16/17 at 12:56 p.m., the DON stated it was her expectation nursing staff have a dignity bag in place for all residents with indwelling urinary catheters.	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 that portion of the assessment.	F 278		9/15/17

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F 278	Continued From page 5 (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 observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) by coding Pressure Ulcers for a resident with non-pressure chronic foot ulcers (Resident #152) and by coding conflicting responses on a resident assessed to have two stage 4 pressure ulcers (Resident #44) for 2 of 2 residents reviewed for Pressure Ulcers. Findings Included: 1. Resident #152 was admitted to the facility on 03/31/17 with the diagnosis of non-pressure chronic ulcer of other part of the foot, left and right. A review of Resident #152's Admission MDS, dated 04/08/17, indicated Resident #152 had 1 unhealed pressure ulcer at Stage 1 or higher, had 1 Stage 4 pressure ulcer and had 1 unstageable pressure ulcer due to coverage of wound bed by	F 278	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 278 Correction for Affected Resident: MDS for resident # 152 with identified	

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F 278	Continued From page 6 slough and/or eschar. During an interview with Nurse #5 on 08/18/17 at 12:22 p.m., Nurse #5 stated due to human error, she coded Resident #152's MDS to reflect him having pressure ulcers on his left and right foot instead of having diabetic foot ulcers. During an interview with the Administrator on 08/18/17 at 3:35 p.m., the Administrator stated it was his expectation the MDS be coded accurately. 2. Resident #44 was admitted to the facility on 07/18/14. Resident #44's diagnoses included peripheral vascular disease, diabetes mellitus type 2 and stage 4 pressure ulcers on right heel and right lower leg. A review of Resident #44's quarterly MDS, dated 06/18/17, indicated Resident #44 was coded as having a stage 1 or greater pressure ulcer and as having no unhealed pressure ulcers at Stage 1 or higher. The MDS was left blank for the sections which required the number of Stage 1, Stage 2, Stage 3 and Stage 4 pressure ulcers. During an interview with Nurse #5 on 08/18/17 at 12:22 p.m., Nurse #5 stated due to human error, the MDS was inaccurately coded. During an interview with the Administrator on 08/18/17 at 3:35 p.m., the Administrator stated it was his expectation the MDS be coded accurately.	F 278	coding error was modified and coding corrected and resubmitted by MDSC on 8/16/17. Identification of Other Potentially Affected Residents: All residents who had documented skin ulcers were reviewed to ensure accurate coding in section M of current or most recent MDS assessment were reviewed by MDSC on 8/17/17. All MDSs with coding errors identified through audit were modified and corrected on 8/17/17 by MDSC. One MDS out of twenty was identified to be coded inaccurately and was modified on 8/17/17 and resubmitted by the MDSC. Systemic Changes: MDSC and MDS Assistant were provided education on how to accurately code Section M of the MDS. This education was provided by the Regional MDS Consultant on 8/17/17 and 8/18/17. Quality Assurance: The most recent MDS for 5 residents who have had documented skin ulcer(s) during the past 90 days will be audited to ensure accurate coding of Section M. These 5 residents will be chosen by running an Assessment History report from Point Click Care that will include all Weekly Pressure Ulcer Reviews and Weekly Wound Reviews (non-pressure) that were completed during the past 90 days. If there are not 5 residents who have or had skin ulcer(s) present during their MDS	

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F 278	Continued From page 7	F 278	assessment period, then 5 random residents who have had an MDS completed within the past 30 days will be reviewed to ensure accurate coding of Section M. This audit will be completed by the MDS Consultant or Nurse Consultant weekly x 4, and then monthly x 2 or until compliance is achieved and sustained. Any concerns identified will be addressed immediately. This audit will be reviewed weekly by the QA committee, consisting of the DON, Social Worker, Dietary Manager, Business Office Manager, Lead Support Nurses, Activity Director, Rehab Director and NHA. Compliance Date: September 15, 2017	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279		9/15/17

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and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

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F 279	Continued From page 9 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for o1 of 29 residents reviewed (Resident #218). Findings Included: 1. Resident #218 was admitted to the facility on 07/21/17 with diagnoses which included benign prostatic hypertrophy (BPH), chronic kidney disease and urinary retention. A review of Resident #218's Admission Minimum Data Set (MDS), dated 07/28/17, indicated Resident #218 had an indwelling urinary catheter. A review of Resident #218's Care Area Assessment (CAA), dated 07/28/17, indicated Resident #218 had an indwelling urinary catheter and was under the care of a urologist due to urinary retention. A review of Resident #218's Admission Care Plan revealed Resident #218 was not care planned for an indwelling urinary catheter. During an interview with the MDS Coordinator on 08/17/17 at 10:45 a.m., the MDS Coordinator stated Resident #218 was originally admitted to the facility on 07/13/17. The MDS Coordinator stated resident was discharged to the hospital and returned to the facility with an indwelling urinary catheter on 07/21/17. The MDS Coordinator stated the indwelling urinary catheter should have been care planned and she just missed it.	F 279	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F 279 Correction for Affected Resident: The care plan for affected resident #218 was updated to reflect that he has an indwelling urinary catheter. This was completed by the MDSC on 8/16/17. Identification of Other Potentially Affected Residents: All residents that have urinary catheters have had their care plan reviewed and updated accordingly to ensure that it accurately reflects presence of urinary catheters. Three out of eighteen care plans were updated. This was completed by the MDS Nurse Consultant on 9/8/2017.	

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F 279	Continued From page 10 During an interview with the Administrator on 08/17/17 at 11:24 a.m., the Administrator stated it was his expectation the MDS Coordinator develop a comprehensive care plan for a resident which accurately reflects the needs of the resident.	F 279	Systemic Changes: MDSC, MDS assistant and Nurse Managers will receive education on importance of reviewing and revising care plans to accurately reflect urinary catheters for all re-admitted and current residents. This education will be provided by the MDS Nurse Consultant by 9/15/17. Quality Assurance: Five residents with urinary catheters will be reviewed to ensure that their care plans accurately reflect the presence of a urinary catheter. This audit will be completed by the MDS Consultant or Nurse Consultant weekly x 4 and then monthly x 2 or until sustained compliance is achieved. Any concerns identified will be addressed immediately. This audit will be reviewed weekly by the QA committee, consisting of the DON, Social Worker, Dietary Manager, Business Office Manager, Lead Support Nurses, Activity Director, Rehab Director and NHA. Compliance Date: September 15, 2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		9/15/17

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F 280	Continued From page 11 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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F 280	Continued From page 12 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record reviews the facility failed to invite the resident to a care plan meeting for 1 of 29 sampled residents (Resident #178) and failed to revise a care plan	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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F 280	Continued From page 13 for 2 of 2 sampled residents Resident #87 who had a urinary catheter after readmission and Resident #218 who had acquired a pressure ulcer. The findings included: 1. Resident #178 was admitted to the facility for the first time 1/19/16 with diagnosis including Dementia without behaviors, Hypertension, and Malnutrition. In an interview with the responsible party for Resident #178 on 8/15/17 at 3:04 PM revealed she and Resident #178 had not been invited to participate in any type of care planning meeting to discuss the goals and treatment objectives. Further interview revealed she would have preferred to attend, but did know when the meeting was held. In an interview with Social Worker #1 and Social Worker #2 on 8/18/17 at 2:50 PM, they revealed they verbally tell the residents and/or family members about the care planning meeting. Information could not be provided to show Resident #178 and the had been invited to any care plan meeting. The Social Workers explained there was no sign in sheet or documentation of the and/or the resident being invited and/or attending any care planning meeting. Interviews with the Administrator on 8/18/17 at 3:17 PM revealed he had just found out the staff was no longer documenting an invitation to care planning. The expectation is all residents and/or responsible parties are invited to all care planning meeting from this point forward.	F 280	To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 280 Correction for Affected Residents: Resident #178 has had care plan meetings held by the interdisciplinary care plan team as evidenced by resident interview. Resident stated the care plan team has met in his room and discussed his therapy goals and discharge plans. Resident is his own responsible party and has a BIMS score of 13. Resident interview conducted on 9/8/17 by QA Nurse Consultant. Resident # 87 has had urinary catheter updated to her care plan on 8/16/17 by the MDS nurse. Resident #218 has had his care plan updated on 8/17/17 by the MDS nurse to reflect current pressure ulcers. Identification of Other Potentially Affected Residents: Thirteen out of fifty seven residents that have had a care plan meeting held within the last 30 days by the interdisciplinary care plan team. Forty four	

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F 280	Continued From page 14 2. Resident #87 was admitted 7/20/17 with cumulative diagnoses of Chronic Kidney Disease, Atrial Fibrillation, Irritable Bowel Syndrome, Hypertension and Diabetes. A review of Resident #87 Admission Minimum Data Set (MDS), dated 7/27/17, revealed Resident #87 was severely cognitively impaired and was totally dependent of staff for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #87 was always incontinent for bowel and bladder. A review of Resident #87's Care Area Assessment (CAA), dated 7/27/17, indicated Resident #87 was originally admitted to the facility on 7/20/17. Resident #87 was re-admitted to the facility on 8/1/17 after a hospitalization and returned to the facility with an indwelling catheter for comfort care related to a terminal illness and an unstageable pressure ulcer. A review of Resident #87's Care Plan revealed a focus of an indwelling catheter related to terminal condition and unstageable pressure ulcer on sacrum was initiated on 8/16/17. During an interview on 8/17/17 at 11:24 AM, the Administrator stated his expectation was the MDS Coordinator should accurately assess each resident and the Care Plan should accurately reflect the needs of each resident. In an interview on 8/17/17 at 2:10 PM, the Minimum Data Set (MDS) Nurse stated that there was no care plan updated and/or revised for the indwelling catheter for Resident #87 on her readmission to the facility. She expressed she	F 280	residents/resident representative out of the fifty seven residents have reported that they have not had an interdisciplinary care plan team meeting in the last 90 days. An interdisciplinary care plan team meeting invitation will be extended/mailed for these forty four residents by September 15, 2017. All residents that have urinary catheters have had their care plan reviewed and updated accordingly to ensure that it accurately reflects presence of urinary catheters. Three out of eighteen care plans were updated. This was completed by the MDS Nurse Consultant on 9/8/2017. All residents that currently have pressure ulcers were reviewed to ensure that their care plans reflected the presence of pressure ulcer(s). This review was completed on 8/17/17 by the MDSC. 9 of 21 residents did not have pressure ulcers appropriately care planned. These 9 care plans were updated on 8/17/17 by the MDSC. Systemic Changes: Interdisciplinary Care plan team will receive education regarding the resident and resident representative's right to be invited and included in the care planning conference at a minimum of once quarterly and reviewing/updating care plans to include urinary catheters and pressure ulcers. This education will be	

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F 280	Continued From page 15 had gotten behind on updating the care plans and had not done it. During an interview with the Director of Nursing (DON) on 8/18/17 at 10:15 AM, the DON stated it was her expectation for care plans to be updated as situations arises for every resident. 3. Resident #218 was initially admitted to the facility 7/13/17 with diagnoses of Chronic Kidney Disease, Coronary Artery Disease, Closed Fracture of Left Femur, and Atrial Fibrillation. A review of Resident #218 Admission Minimum Data Set (MDS), dated 7/29/17, revealed Resident #218 was cognitively impaired and required extensive assistance and one person physical assist for bed mobility, toileting, and personal hygiene. The MDS indicated Resident #218 was frequently incontinent for bowel and bladder. A review of Resident #218's Care Area Assessment (CAA), dated 7/29/17, indicated Resident #218 was originally admitted to the facility on 7/13/17. Resident #218 was re-admitted to the facility on 7/21/17 after a hospitalization for Severe Sepsis related to Pneumonia and an Urinary Tract Infection. A review of Resident #218's Care Plan revealed a focus of at risk for pressure ulcer development initiated on 8/01/17. A review of Resident #218's Physician Orders dated 7/31/17 revealed an order for clean right heel with wound cleanser and apply Calcium Alginate and dry dressing every day shift for deep tissue injury.	F 280	provided by the MDS Nurse Consultant by 9/15/17. Quality Assurance: An audit of 5 residents and/or their resident representative will be interviewed to ensure that they have been invited and participated in the care planning processes. This audit will be conducted weekly x 4 and then monthly x 2. This audit will be completed by the Social Worker or Activity Director weekly x 4 and then monthly x 2 or until sustained compliance is achieved. Any concerns identified will be addressed immediately. This audit will be reviewed weekly by the QA committee, consisting of the DON, Social Worker, Dietary Manager, Business Office Manager, Lead Support Nurses, Activity Director, Rehab Director and NHA. Compliance Date: September 15, 2017	

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F 280	Continued From page 16 During an interview on 8/17/17 at 11:24 AM, the Administrator stated his expectation was the MDS Coordinator should accurately assess each resident and the Care Plan should accurately reflect the needs of each resident. In an interview on 8/17/17 at 2:10 PM, the Minimum Data Set (MDS) Nurse stated that there was no care plan updated and/or revised for the pressure ulcer for Resident #218 on the readmission to the facility. She expressed she had gotten behind on updating the care plans and had not done it. During an interview with the Director of Nursing (DON) on 8/18/17 at 10:15 AM, the DON stated it was her expectation for care plans to be updated as situations arises for every resident.	F 280		
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, Physician and staff interviews the facility failed to follow the care plan for use of a medium pad and 2 people while transferring a resident with a use of a lift, resulting in a subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues	F 282	Past noncompliance: no plan of correction required.	9/8/17

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that cover the brain) for 1 of 1 sampled resident. (Resident # 125)
The findings included:

Resident # 125 was admitted to the facility on 3/23/2017 with diagnoses which included acute hypernatremia, acute kidney injury, acute metabolic encephalopathy, agitation, altered mental status, dehydration, generalized weakness and dementia.
Resident #125's care plan dated 5/24/2017 indicated "the resident has an Activities of Daily Living (ADLs) self-care performance deficit." The care plan indicated the goal as "I will maintain current level of function in bed mobility and transfer through the next 90 days." The care plan interventions included use of full mechanical lift for all transfers using a medium pad and assist with use of 2 persons.

The quarterly Minimum Data Set (MDS) dated 7/3/2017 indicated Resident #125 was severely cognitively impaired. The MDS also indicated the resident required extensive assistance of one person for bed mobility and extensive assistance of two person for transfer from bed to wheel chair. The MDS also indicated the resident was totally dependent on staff for all Activities of Daily Living (ADLs). The resident was not coded for falls and walking did not occur during the look back period.
The resident's Kardex dated August/July 2017 (a care guide for direct staff identifying resident care needs at the facility) under transfer headline indicated the resident required a full mechanical lift for transfers using 2 persons and the use of medium pad size.

A nurse note dated 7/24/2017 at 12:57 PM

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revealed "the nurse was called to the resident's room around 11:40 am due to the resident's fall. When the nurse entered the room she noted the resident lying on the floor next to bed lying on her left side. NA # 1 stated the resident fell on her back with head being bumped noted alert and verbal with sitter and staff NA#1 was with the resident. A raised area to back of the head was noted and no bleeding was noted. NA# 1 stated that the resident was being transferred from bed to wheel chair when a fall occurred. The doctor was called and the responsible party was notified. The patient was then sent out to an emergency room for an evaluation."

A nurse note dated 7/24/2017 at 5:00 PM revealed the resident was admitted back to the facility from the emergency room with no new medication but with an order for the facility to stop the use of aspirin medication.

Review of the emergency room report dated 7/24/2017 indicated the resident was diagnosed with subarachnoid hemorrhage. The report also revealed the doctors discussed transferring the resident to a neurosurgical care center with the family member, but the family member declined to have the patient transferred. The resident was subsequently transported back to the nursing home facility on 07/24/2017.

Review of the facility's investigation report dated 7/24/2017 revealed "Resident, # 125 was being transferred by Nurse Aide (NA) # 1 using the Maxi-move lift (full mechanical lift) with a XL (Extra Large) lift pad. During the transfer NA# 1 reported lift pad became unhooked on 1 corner. Initially, the resident sustained a hematoma to the back of her head. The resident was immediately

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assessed by Nurse # 1. The doctor was notified and orders were obtained to send the patient for evaluation. Under the investigation headline the report indicated, "The resident was assessed to use a medium lift pad for transfers. The resident's care guide listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the care guide before giving care and transfers. The NA # 1 failed to check the care guide as a result, the NA#1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA#1 reenacted the lift transfer by demonstrating to the Administrator the following: NA demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss-crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer. The NA # 1 was asked at the time of interview by Administrator why she did not have another staff member present during lift use and NA#1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA#1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17."

During the interview with NA #1 on 8/16/2017 at 12:30 PM, she verified she did not use the correct pad size while transferring the resident and she did not have another staff with her in the room while transferring the resident. NA #1 further reported on 7/24/2017 while in the process of transferring the resident from bed to wheelchair, she (Resident # 125) fell on the floor. NA # 1 also reported she was aware of where the Kardex was located which indicated the resident was to be

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transferred using medium size pad and use of 2 people. NA #1 also reported she always used 2 persons while transferring a resident but she was in a hurry and used one person for the transfer. During the interview with Nurse # 1 on 8/16/2017 at 1:00 PM, she reported that on 7/24/2017 she was called to resident #125's room by NA #1 who stated she transferred the resident alone and the resident fell on the floor. Nurse #1 also reported she assessed the resident and she found the resident had a bump by the side of the head. She (Nurse # 1) then notified the Physician who ordered the patient to be sent to the emergency room. Nurse # 1 further added the resident came back to the facility the same day with the diagnosis of subarachnoid hemorrhage.

During the interview with the Physician on 8/17/2017 at 11:00 AM, the Physician reported he evaluated the resident immediately after the fall and the resident was doing remarkably well. He indicated since the resident's fall on 7/24/2017, the facility staff were continuing to monitor the resident closely for any changes in cognition or her health. The doctor also reported the resident was not a candidate for surgery due to age. He further mentioned the resident will continue to be evaluated by the neurosurgeon and an appointment had been set up by the facility staff.

On 8/17/2017 at 1:30 PM, observation of Resident #125 in her wheel chair revealed no grimacing or behaviors to indicate she was in pain and no bump on the head. The NA # 2 and NA # 3 were also observed transferring the resident from the wheel chair to bed. The staff used assigned pad size (medium) and lift belt securement the proper procedure while transferring the resident. No concerns were

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F 282	Continued From page 21 identified During the interview with the facility Administrator on 8/18/2017 at 10:50 am, she stated she had investigated the circumstances of Resident # 125's fall on 7/24/2017 and determined that NA #1 had not followed the care plan interventions for the use of 2 staff members while transferring the resident and had not used the right pad size. The Administrator stated his expectation was for the NA# 1 to have followed the care plan while transferring a resident. The Administrator also added that NA # 1 was aware the resident needed 2 persons and the use of correct pad size while transferring a resident because she had been in serviced on 10/25/2016 and 5/29/2017. Facility provided corrective action plan on 8/16/2017 Description of event: Resident # 125 was being transferred by NA#1 using the Maxi-move lift with a XL lift pad. During the transfer NA #1 reports lift pad became unhooked on 1 corner. Initially, the resident sustained a hematoma to the back of her head. The resident was immediately assessed by Nurse # 1. The Physician was notified and orders were obtained to send to ER for evaluation. This was completed on 07/24/2017. The resident was assessed to use a medium lift pad for transfers. The Kardex listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the Kardex before giving care and transfers. The NA # 1 failed to check the Kardex as a result, the NA # 1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA # 1reenacted the lift transfer by demonstrating to the Administrator the following: NA # 1 demonstrated by re-enactment of lifting	F 282		

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the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss- crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer.

The NA # 1 was asked at time of interview by Administrator why she did not have another staff member present during lift use and NA # 1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA # 1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17.

After review of the investigation of the event, it is identified, the root causes to be as follows:
-NA# 1 failed to review Kardex prior to transfer
-NA # 1used incorrect lift sling
-NA# 1 attached leg straps to the cradle incorrectly
- NA# 1 failed to have second trained staff member present during lift transfer

Corrective Action for Affected Residents
The resident was immediately assessed and the provider was notified by Nurse # 1 at 11:50 AM. Pain was also assessed. Responsible Party was notified by Nurse # 1 on 7/24/17 at approximately. 11:55 AM. The resident was transferred to the hospital at 12:05 PM.
Corrective Action for Potentially Affected Residents
All lift slings on 7/24/2017 were inspected with all/any issues corrected or equipment removed from service immediately. All nursing staff received in-service education with return demonstration for accessing the Kardex &

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executing proper transfers using all types of facility lifts.
Education will be provided to all clinical staff on the following:
-Using the Kardex to identify the correct lift and sling size
-Appropriate processes of lift usage, including number of staff required
All nurses and CNA's will perform return demonstration for lift usage.
Systematic Changes
Education provided to all Nurses and Nurse Assistants on the utilization of resident Kardexes and using the correct lift for safe resident transfers. Education will be provided by the Staff Development coordinator (SDC). This education will be included in new hire orientation for nurses and CNAs.
Return demonstration to validate competency of the staff showing correct usage of the lift pads with the lifts will be performed.
Any education not completed on 8/7/17 will result in staff being removed from the schedule until education is complete. All nursing staff including: LPNs, RNs, Nursing Managers, CNAs and Med. Aides/Techs Were in serviced on the importance of checking resident Kardex prior to initiating any transfers in order to ensure that the safest transfer technique is used. This education was initiated on 7/24/17 by the Staff Development Coordinator. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The education completion date on 8/7/2017.

HOW THE FACILITY PLANS TO MONITOR

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CHANGES IMPLEMENTED

The Staff nurses or licensed nurse will complete a Safe Transfer/Lift Quality Assurance (QA) Audit weekly x 4 and then monthly x 2 making sure the correct lift pad is being used with correct lift on the correct resident. The Director of Nursing will present findings to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Unit Managers, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Health Information Management and meets weekly.

As part of the validation on 8/17/2017 at 3:30 PM, the entire plan of correction was reviewed including the interviews with staff related to the use of the lift. Interview with the Nurses' Aides revealed they had knowledge in checking the residents' Kardex and following the interventions before using a lift to transfer a resident. The staff were reeducated on a safe transfer with use of a lift and making sure the correct lift pad is used with correct lift on the correct resident. 2 staff were observed during a transfer of Resident # 125. The 2 staff appropriately transferred the resident by making sure the correct lift pad (medium size) was used with correct lift. Review of the facility's Audit of appropriate use of lift revealed a nurse supervisor on each unit observed 5 random residents who required a use of mechanical lift while being transferred by 2 nurses' aides. The audit revealed no concerns were identified for the last 4 weeks.

Quality Assurance committee report revealed the facility met daily to discuss the appropriate use of

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F 282	Continued From page 25 lift audit beginning 7/25/2017 until 8/11/2017. Review of the monitoring tools revealed that the facility had completed the 100% in-service on 8/7/2017.	F 282		
F 323 SS=G	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 record review, observations, and staff interviews the facility failed to use designated pad size (medium) and use 2 people while transferring a resident using a full mechanical lift,	F 323	Past noncompliance: no plan of correction required.	9/8/17

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resulting in a subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover the brain) for 1 of 1 sampled resident who was care planned for use of a lift. (Resident # 125)
The findings included:

The user manual instruction manual for use of the mechanical lift dated January 2015 was reviewed. The instruction indicated the following:
- Do not use a sling unless it is recommended for use with the lift.
- Always check the sling is suitable for the particular patient and is of the correct size and capacity.
Resident # 125 was admitted to the facility on 3/23/2017 with diagnoses which included acute hypernatremia, acute kidney injury, acute metabolic encephalopathy, agitation, altered mental status, dehydration, generalized weakness and dementia.
Resident #125's care plan dated 5/24/2017 indicated "the resident has an Activities of Daily Living (ADLs) self-care performance deficit." The care plan indicated the goal as "I will maintain current level of function in bed mobility and transfer through the next 90 days." The care plan interventions included use of full mechanical lift for all transfers using a medium pad and assist with use of 2 persons.

The quarterly Minimum Data Set (MDS) dated 7/3/2017 indicated Resident #125 was severely cognitively impaired. The MDS also indicated the resident required extensive assistance of one person for bed mobility and extensive assistance of two person for transfer from bed to wheel chair. The MDS also indicated the resident was totally dependent on staff for all Activities of Daily

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Living (ADLs). The resident was not coded for falls and walking did not occur during the look back period.

The resident's Kardex dated August/July 2017 (a care guide for direct staff identifying resident care needs at the facility) under transfer headline indicated the resident required a full mechanical lift for transfers using 2 persons and the use of medium pad size.

A nurse note dated 7/24/2017 at 12:57 PM revealed "the nurse was called to the resident's room around 11:40 am due to the resident's fall. When the nurse entered the room she noted the resident lying on the floor next to bed lying on her left side. NA # 1 stated the resident fell on her back with head being bumped noted alert and verbal with sitter and staff NA#1 was with the resident. A raised area to back of the head was noted and no bleeding was noted. NA# 1 stated that the resident was being transferred from bed to wheel chair when a fall occurred. The doctor was called and the responsible party was notified. The patient was then sent out to an emergency room for an evaluation."

A nurse note dated 7/24/2017 at 5:00 PM revealed the resident was admitted back to the facility from the emergency room with no new medication but with an order for the facility to stop the use of aspirin medication.

Review of the emergency room report dated 7/24/2017 indicated the resident was diagnosed with subarachnoid hemorrhage. The report also revealed the doctors discussed transferring the resident to a neurosurgical care center with the family member, but the family member declined

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to have the patient transferred. The resident was subsequently transported back to the nursing home facility on 7/24/2017.

Review of the facility's investigation report dated 7/24/2017 revealed "Resident, # 125 was being transferred by Nurse Aide (NA) # 1 using the Maxi-move lift (full mechanical lift) with a XL (Extra Large) lift pad. During the transfer NA# 1 reported lift pad became unhooked on 1 corner. Initially, the resident sustained a hematoma to the back of her head. The resident was immediately assessed by Nurse # 1. The doctor was notified and orders were obtained to send the patient for evaluation. Under the investigation headline the report indicated, "The resident was assessed to use a medium lift pad for transfers. The resident's care guide listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the care guide before giving care and transfers. The NA # 1 failed to check the care guide as a result, the NA#1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA#1 reenacted the lift transfer by demonstrating to the Administrator the following: NA demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss-crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer. The NA # 1 was asked at the time of interview by Administrator why she did not have another staff member present during lift use and NA#1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA#1 had received recent lift training regarding having 2 staff members with

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mechanical lifts on 10/25/16 and 5/29/17."

During the interview with NA #1 on 8/16/2017 at 12:30 PM, she verified she did not use the correct pad size while transferring the resident and she did not have another staff with her in the room while transferring the resident. NA #1 further reported on 7/24/2017 while in the process of transferring the resident from bed to wheelchair, she (Resident # 125) fell on the floor. NA # 1 also reported she was aware of where the Kardex was located which indicated the resident was to be transferred using medium size pad and use of 2 people. NA #1 also reported she always used 2 persons while transferring a resident but she was in a hurry and used one person for the transfer. During the interview with Nurse # 1 on 8/16/2017 at 1:00 PM, she reported that on 7/24/2017 she was called to resident #125's room by NA #1 who stated she transferred the resident alone and the resident fell on the floor. Nurse #1 also reported she assessed the resident and she found the resident had a bump by the side of the head. She (Nurse # 1) then notified the Physician who ordered the patient to be sent to the emergency room. Nurse # 1 further added the resident came back to the facility the same day with the diagnosis of subarachnoid hemorrhage.

During the interview with the Physician on 8/17/2017 at 11:00 AM, the Physician reported he evaluated the resident immediately after the fall and the resident was doing remarkably well. He indicated since the resident's fall on 7/24/2017, the facility staff were continuing to monitor the resident closely for any changes in cognition or her health. The doctor also reported the resident was not a candidate for surgery due to age. He further mentioned the resident will continue to be

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evaluated by the neurosurgeon and an appointment had been set up by the facility staff.

On 8/17/2017 at 1:30 PM, observation of Resident #125 in her wheel chair revealed no grimacing or behaviors to indicate she was in pain and no bump on the head. The NA # 2 and NA # 3 were also observed transferring the resident from the wheel chair to bed. The staff used assigned pad size (medium) and lift belt securement the proper procedure while transferring the resident. No concerns were identified
During the interview with the facility Administrator on 8/18/2017 at 10:50 am, she stated she had investigated the circumstances of Resident # 125's fall on 7/24/2017 and determined that NA #1 had not followed the care plan interventions for the use of 2 staff members while transferring the resident and had not used the right pad size. The Administrator stated his expectation was for the NA# 1 to have followed the care plan while transferring a resident. The Administrator also added that NA # 1 was aware the resident needed 2 persons and the use of correct pad size while transferring a resident because she had been in serviced on 10/25/2016 and 5/29/2017.

Facility provided corrective action plan on 8/16/2017
Description of event:

Resident # 125 was being transferred by NA#1 using the Maxi-move lift with a XL lift pad. During the transfer NA #1 reports lift pad became unhooked on 1 corner. Initially, the resident sustained a hematoma to the back of her head. The resident was immediately assessed by Nurse # 1. The Physician was notified and orders were

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obtained to send to ER for evaluation. This was completed on 07/24/2017.
The resident was assessed to use a medium lift pad for transfers. The Kardex listed the correct lift pad to be used. NA # 1 was aware of the process of reviewing the Kardex before giving care and transfers. The NA # 1 failed to check the Kardex as a result, the NA # 1 failed to use the correct lift pad for transfer, resulting in an improper transfer. The NA # 1reenacted the lift transfer by demonstrating to the Administrator the following: NA # 1 demonstrated by re-enactment of lifting the resident using the XL lift pad with the Maxi-move (total lift device). She demonstrated incorrectly criss- crossing the leg straps to the lift bar reporting that she and the private sitter were present at time of transfer.

The NA # 1 was asked at time of interview by Administrator why she did not have another staff member present during lift use and NA # 1 stated, "That she normally does, but the sitter was in the room". Administrator informed her this was not acceptable as the sitter was not a trained employee. NA # 1 had received recent lift training regarding having 2 staff members with mechanical lifts on 10/25/16 and 5/29/17.

After review of the investigation of the event, it is identified, the root causes to be as follows:
-NA# 1 failed to review Kardex prior to transfer
-NA # 1used incorrect lift sling
-NA# 1 attached leg straps to the cradle incorrectly
- NA# 1 failed to have second trained staff member present during lift transfer

Corrective Action for Affected Residents
The resident was immediately assessed and the

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provider was notified by Nurse # 1 at 11:50 AM. Pain was also assessed. Responsible Party was notified by Nurse # 1 on 7/24/17 at approximately. 11:55 AM. The resident was transferred to the hospital at 12:05 PM.
Corrective Action for Potentially Affected Residents
All lift slings on 7/24/2017 were inspected with all/any issues corrected or equipment removed from service immediately. All nursing staff received in-service education with return demonstration for accessing the Kardex & executing proper transfers using all types of facility lifts.
Education will be provided to all clinical staff on the following:
-Using the Kardex to identify the correct lift and sling size
-Appropriate processes of lift usage, including number of staff required
All nurses and CNA's will perform return demonstration for lift usage.
Systematic Changes

Education provided to all Nurses and Nurse Assistants on the utilization of resident Kardexes and using the correct lift for safe resident transfers. Education will be provided by the Staff Development coordinator (SDC). This education will be included in new hire orientation for nurses and CNAs.

Return demonstration to validate competency of the staff showing correct usage of the lift pads with the lifts will be performed.
Any education not completed on 8/7/17 will result in staff being removed from the schedule until education is complete. All nursing staff including: LPNs, RNs, Nursing Managers, CNAs and Med.

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Aides/Techs Were in serviced on the importance of checking resident Kardex prior to initiating any transfers in order to ensure that the safest transfer technique is used. This education was initiated on 7/24/17 by the Staff Development Coordinator. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The education completion date on 8/7/2017.

HOW THE FACILITY PLANS TO MONITOR CHANGES IMPLEMENTED

The Staff nurses or licensed nurse will complete a Safe Transfer/Lift Quality Assurance (QA) Audit weekly x 4 and then monthly x 2 making sure the correct lift pad is being used with correct lift on the correct resident. The Director of Nursing will present findings to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Unit Managers, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Health Information Management and meets weekly.

As part of the validation on 8/17/2017 at 3:30 PM, the entire plan of correction was reviewed including the interviews with staff related to the use of the lift. The staff were reeducated on a safe transfer with use of a lift and making sure the correct lift pad is used with correct lift on the correct resident. 2 staff were observed during a transfer of Resident # 125. The 2 staff appropriately transferred the resident by making

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F 323	Continued From page 34 sure the correct lift pad (medium size) was used with correct lift. Review of the facility's Audit of appropriate use of lift revealed a nurse supervisor on each unit observed 5 random residents who required a use of mechanical lift while being transferred by 2 nurses' aides. The audit revealed no concerns were identified for the last 4 weeks. Quality Assurance committee report revealed the facility met daily to discuss the appropriate use of lift audit beginning 7/25/2017 until 8/11/2017. Review of the monitoring tools revealed that the facility had completed the 100% in-service on 8/7/2017.	F 323		
F 371 SS=D	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	F 371		9/15/17

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F 371	Continued From page 35 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 by: Based on observation, record review and resident and staff interviews, the facility failed to wash and sanitize residents' water pitchers and plastic straws for 1 of 1 resident's (Resident #76) water pitcher observed. Findings included: A review of Resident #76's quarterly Minimum Data Set (MDS), dated 05/14/17, revealed Resident #76 was cognitively intact and required extensive assistance to total dependence on staff for her Activity of Daily Living. During an observation and interview of Resident #76 on 08/15/17 at 2:10 p.m., Resident #76 was seated in her wheelchair in her room. Resident #76's water pitcher was observed to be placed within her reach on her over-bed table. The straw was observed to be gray-black in color. Upon further inspection of the straw, an unknown substance resembling black flecks lined the inside of the straw. When asked how often her water pitcher and straw were washed, Resident #76 stated she did not know. The resident stated it made her feel bad knowing she had been drinking out of a dirty straw. During an interview with Nursing Assistant (NA) #1 on 08/15/17 at 2:15 p.m., NA #1 stated the residents' water pitchers and straws never go to the kitchen to be washed and sanitized. NA #1 stated she thought the 3rd shift NAs took the cups to the Nourishment Room and rinsed them	F 371	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 371 Corrective Action for Resident Affected Resident #76 received a new water pitcher with a new straw on 8/15/17 by nursing assistant J.K. Corrective Action for Resident Potentially Affected On 8/15/17, all water pitchers and straws were cleaned and/or replaced by the nursing assistant staff. The facility is to ensure that all resident water pitchers are washed and sanitized on a regular basis per facility schedule. Systemic Changes An in-service to review, educate and	

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MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328

(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 371	Continued From page 36 out but stated she was not sure. During an interview with the Dietary Manager (DM) on 08/15/17 at 2:20 p.m., the DM stated there was a schedule for washing and cleaning the residents' water pitchers and straws and provided a copy of the schedule from a notebook in the Dietary Department. During an interview with Nurse #6 on 08/15/17 at 2:26 p.m., Nurse #6 stated residents' water pitchers and straws did not go to the kitchen to be washed and sanitized. Nurse #6 stated they would get a new water pitcher and straw for a resident they became soiled. During an interview with the Administrator on 08/18/17 at 3:32 p.m., the Administrator stated he had not been aware the residents' water pitchers and straws were not being taken to the kitchen to be washed and sanitized. The Administrator stated it is his expectation the cleaning schedule for the residents' water pitchers and straws will be followed and the water pitchers will be taken to the kitchen to be washed and sanitized.	F 371	provide instruction on Cleaning and Sanitizing Water Pitchers Policy was conducted for all nursing staff on August 16th 2017 by the Administrator. An in-service to provide instruction on Water Pitchers and Disposable Straw Usage will be conducted for all dietary and nursing staff by LTC Staff Development Coordinator by September 15th 2017. All FT, PT and PRN staff will receive the education. Any staff not receiving the education, will not be permitted to work until receiving the education by September 15, 2017. Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be done weekly for four weeks, including weekends, and then monthly for two months. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director, Unit Managers, Business Office Manager, Activity Director, and Social Worker. Compliance Date: September 15, 2017	