STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARMOUNT HEALTH AND REHAB CENTER	109 S HOLDEN ROAD GREENSBORO, NC 27407

(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=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (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 reviews, resident and staff interviews the facility failed to provide incontinence care when requested, resulting in compromised dignity for 3 of 4 residents who required extensive assistance with personal hygiene. Resident # 26, Resident #113, and Resident #111. Findings included: 1. Resident #26 was admitted to the facility on 05/17/17 with current diagnoses of chronic obstructive pulmonary disease, hypothyroism, and obstructive sleep apnea. A review of the concern logs from 06/17 until present revealed that Resident #26 had concerns about her call bell not being answered in a timely manner. On 08/08/17 the resident had urinated and her bed was soaked before staff answered her call bell. Review of Resident #26's quarterly Minimum Data Set (MDS) dated 08/21/17, revealed that Resident #26 was cognitively intact, legally blind and able to make her needs known. The resident required extensive assistance for personal hygiene with one person physical assist, and for bathing Resident #26 was totally dependent on	F 241	Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and / or executed solely because it is required by provisions of federal and state law. Per review of concern log and interviews with the surveyors Residents #26, #113, #111 stated their call bells were not answered timely. Per interview with the surveyors Residents #26, #113 and #111 were not provided care timely. Call bells are being answered timely. Timely Incontinent care is being provided as requested and or as needed. Staff members are to respond to call bells in a timely manner and address the residents requests, if able, at that time. If staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff is to interact with residents in a respectable manner. Staff members were in-serviced by the	10/12/17

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

Electronically Signed | 10/05/2017

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F 241	Continued From page 1 staff with one person physical assist. Resident #26 was frequently incontinent of bowel and bladder. Further review of the concern log revealed Resident #26 had another concern dated 08/31/17 that she had another episode of urinary incontinence and her bed was soaked before staff answered her call bell. During an interview on 09/11/17 at 6:45 PM Resident #26 revealed that during her first week on the long hall she waited 2 hours or longer to be changed. Resident # 26 indicated when she put on her call bell no one answered. Resident # 26 indicated because she waited so long she soiled herself (with urine and bowel movement). Resident #26 indicated that was a bad feeling waiting so long to be changed. Resident #26 indicated that this all had been reported to the facility. Resident #26 indicated she wanted to go to another facility and hoped that staff would care for her and help her feel better about her situation. During an interview with the Social Worker on 09/13/17 at 2:30 PM she revealed that she had moved Resident #26 on 09/06/17 to a new room. The SW indicated during this interview that Resident #26 had issues with her call bell not being answered and staff not changing her. During an interview with Nursing Assistant (NA) #3 for Resident # 26 on 09/13/2017 at 3:30 PM, she revealed that she had only been working with Resident #26 for two days. NA #3 indicated she had not had any concerns with this resident and that she always treated her residents with respect and dignity.	F 241	Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that staff is to interact with residents in a respectable manner. Nursing staff were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. The Administrator, Director of Nursing, Unit Managers and Nurse Supervisors will conduct ten random resident observations per week to validate call bells are responded to in a timely manner. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) will interview ten residents per week to validate timely provision of incontinent care. The Department Managers will interview ten residents per	

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F 241	Continued From page 2 During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM, she indicated that her expectations were for all staff to answer a call bell within 3-5 minutes. Her expectation would be that all staff treat all residents with respect and dignity and showers be given as scheduled. 2. Resident # 113 was admitted to facility on 06/30/2017 with the current diagnoses of hypertension, seizure disorder and cerebral palsy. Resident #113 Minimum Data Set (MDS) dated 07/07/17 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility, transfers, toilet use with two person physical assist, and with locomotion, dressing, and personal hygiene she required extensive assistance with one person physical assist. The resident was incontinent of bladder and incontinent of bowel. During an Interview with Resident # 113 on 09/12/2017 at 2PM, Resident #113 indicated that last week (09/04/17 through 09/10/17) she waited in her bed for 2 hours for staff to change her. She indicated that her call bell was on and NA# 34 came in, cut off her call bell, and stated she would be back in a few minutes, and it was an hour before the NA came back to change her. Resident #113 indicated that her buttocks were red and had a rash on it from waiting so long. Resident # 113 indicated that she was admitted to the facility on 6/30/2017 and this has been an issue since her placement. Resident #113 also revealed she had several falls because staff did not respond to the call bell. Resident # 113 indicated that her roommate had a clock on the wall in front of her bed, and this was how she	F 241	week to validate residents are being treated in a respectable manner. The Administrator will present the results of the call bell audit and the Director of Nursing will present the results of the timely incontinence care audit to the center□s Quality Assurance and Performance Improvement Committee. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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knew how long she waited for staff to answer her call bell. Resident # 113 revealed that on 09/09/17 or 09/10/17 she waited in her urine and feces for over two hours and she believed that was how she got the rash on her bottom. Resident #113 indicated her brief was soiled a lot during the day. Resident #113 indicated this made her feel bad having to wait so long to receive care. Resident #113 revealed she felt sad and down a lot in the facility because staff were so slow and their attitudes are not the greatest but she had to get better so she could go home.

During an interview with Nursing Assistant (NA) #34 on 09/13/2017 at 2:45 PM, she revealed she was not the NA that left Resident # 111 in her urine and feces last week but it was NA #43. NA #34 revealed she would never leave any residents soaked in urine and feces that long. NA #34 also indicated she would never go in a resident's room and cut off the call bell without coming back in 10 to 15 minutes to provide care and treatment.

During an Interview with NA #43 on 09/14/2017 at 10 AM, NA #43 indicated that she would never leave a resident in urine and feces for that long.

During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM, she indicated that her expectations were for all staff to answer a call bell within 3-5 minutes. Her expectation would be that all staff treat all residents with respect and dignity.

3. Resident # 111 was admitted to facility on 08/05/2015 with the current diagnoses of hypertension, diabetes mellitus and hyperlipidemia.

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Resident #111's quarterly Minimum Data Set (MDS) dated 08/30/2017 revealed the resident was cognitively intact. The resident required extensive assistance with personal hygiene with one person physical assist and for bathing Resident #111 was totally dependent upon staff with two personal physical assist. The resident was always incontinent of bladder and always incontinent of bowel.

During an interview with Resident # 111 on 09/12/2017 at 1:30 PM, she indicated (the week of 09/04/17 through 09/10/17), she waited in her bed for 2 hours for staff to change her. She indicated that her call bell was on and Nursing Assistant # 34 came in, cut off the call bell, and stated she would be back in a few minutes but it was an hour before she came back. Resident # 111 indicated that her buttocks were red and she had a rash from waiting so long. Resident # 111 also revealed that this had happened several times during her stay. Resident # 111 indicated that she had a clock on the wall in front of her bed and that was how she knew how long she waited for staff to answer her call bell. Resident # 111 revealed that on 09/06/17 or 09/09/17, she waited in her urine and feces for over two hours, and she believed that incident caused her red bottom. Resident #111 indicated that this made her feel bad that staff took so long to provide care for her.

During a second interview with Resident #111 on 0 9/13/2017 at 2:10 PM, she indicated that she felt terrible about being wet and dirty on 09/09/17 or 09/10/17. She stated her bottom was sore and it was not a great feeling lying in her urine and feces for a long time.

During an interview with Nursing Assistant (NA)

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F 241	Continued From page 5 #34 on 09/13/2017 at 2:45 PM, she stated she was not the NA that left Resident # 111 in her urine and feces the previous week but it was NA #43. NA #34 revealed she would never leave any residents soaked in urine and feces that long. NA #34 also indicated she would never go in a resident's room and cut off the call bell without coming back in 10 to 15 minutes to provide care and treatment. During an Interview with NA #43 on 09/14/2017 at 10 AM, NA #43 indicated that she would never leave a resident in urine and feces for that long. During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM, she indicated that her expectations for all staff to answer a call bell within 3-5 minutes. Her expectation would be that all staff treat all residents with respect and dignity.	F 241		
F 242 SS=D	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 242		10/12/17

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F 242	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews the facility failed to honor a resident's choice to get out of bed early for 1 of 3 residents reviewed for choices (Resident #135.) Finding included: Resident # 135 was admitted to the facility on March 22, 2016 with cumulative diagnoses which included hypertension, chronic pain and pneumonia organism. Review of the Minimum Data Set (MDS) dated July 13, 2017 revealed Resident #135 was alert and oriented was cognitively intact and able to make her needs known to staff. Resident # 135 needed extensive to total assistance from staff for the completion of all of her activities of daily living except for eating. A review of her care plan dated August 24, 2017 revealed there were no interventions about getting Resident #135 up at 5:30AM nor was it observed on her care card. During an observation on September 12, 2017 at 10:30AM, Resident # 135 was still in bed with her bed clothes on. During an interview with Resident # 135 on September 12, 2017 at 11:01 AM Resident # 135 revealed that she had been asking to get out of bed since 5:30 AM and no one would get her up. Resident #135 indicated "I am a country girl up with the chicken every day all my life". During this interview Resident #135 was observed with her bed clothes on.	F 242	Resident #135 requested to the Social Worker get up early. The Social Worker forgot to notify nursing staff resulting in Resident #135 staying in bed longer than her preference. Resident #135 Care Plan was updated per her preference. Resident #135 is currently going to and getting up from bed per her choice. Staff members are to honor resident preferences for time of going to and getting out of bed. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) interviewed alert and oriented residents to determine residents choices for time of going to and getting out of bed. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) interviewed family members, where available, for residents who are not alert and oriented, to determine resident times for going to and getting out of bed. Nursing staff were in-serviced by the by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on honoring resident preferences for time of going to and getting out of bed and honoring resident	

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F 242	Continued From page 7 During an observation at 11:30 AM on September 12, 2017 Resident #135 was observed being transported down to the main dining room. Resident # 135 indicated "they got me up." Observation on September 13, 2017 Resident # 135 was observed in bed at 7 AM with her bed clothes on. Observation on September 13, 2017 Resident #135 was observed in bed at 9 AM with her bed clothes on. Observation on September 13, 2017 Resident #135 was observed up in her wheel chair out of her room near the nurse's station at 10:30 AM. During an interview with Social Worker (SW) at 11 AM on September 13, 2017 revealed that SW knew that Resident #135 requested to get up on third shift (11:00 PM - 7:00 AM.) The SW indicated that she believed that third shift was getting her dressed and putting her back to bed. SW indicated that Resident #135 would be up by 8 AM. During an interview with NA # 35 on September 13, 2017 at 11:30 AM she revealed that she had worked with Resident #135 and was not aware that she wanted to get up so early. During an second interview with the SW on September 13, 2017 at 2: 30PM, the SW indicated that she talked with Resident # 135 who still wanted to get up at 5:30 AM. During an interview with the Director of Nursing (DON) on September13, 2017 at 2:35PM, she	F 242	choices. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director, and the Scheduler) will interview ten residents per week to validate residents choices for going to and getting out of bed times are being honored. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Social Services monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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F 242	Continued From page 8 revealed each resident's choice of time to get up early should be honored.	F 242		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and resident interview the facility failed to replace water damaged ceiling tiles in 4 out of 4 rooms (112,113,115 and 132,). The facility also failed to repair leaks in the roof and failed to repair vertical blinds and a broken window in 1 of 1 rooms (109). The findings included: 1a: An observation of room 112 occurred on 9-12-17 at 9:25am. The bathroom in room 112 was noted to have water stains on the ceiling tiles. An observation of room 112 occurred on 9-13-17 at 2:00pm. The bathroom in room 112 was noted to have water stains on the ceiling tiles. 1b: An observation of room 113 occurred on 9-12-17 at 8:30am. The ceiling tiles in this room were noted to have water stains present. An observation of room 113 occurred on 9-13-17 at 1:50pm. Three of the ceiling tiles in this room were noted to have water stains on them. 1c: An observation of room 115 occurred on	F 253	The facility did not complete Maintenance Request Forms to communicate repairs to the window, blinds and stained ceiling tiles to perform corrections. Rooms 112, 113, 115 and 132 stained ceiling tiles were replaced in the bathroom and bedrooms. Room 109 blinds and window were replaced. Repairs to resident rooms are to be addressed in a timely manner. Staff will communicate concerns and issues written on a Maintenance Request Form for minor repairs. Any concern/repair that may affect resident safety, the concern will be immediately reported to the Maintenance Director and or Supervisor on Duty and or Administrator. Maintenance will present Maintenance Request Forms from the previous day in the daily Department Head Stand Up Meeting to the Administrator. Maintenance Request Forms will be reviewed for completion and any outstanding work orders will be presented to be completed that day. Staff were in-serviced by the	10/12/17

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F 253	Continued From page 9 9-12-17 at 10:00am. There were water stains noted on the ceiling tiles in both the bedroom area and the bathroom. An observation of room 115 occurred on 9-13-17 at 1:50pm. The ceiling tiles in both the bedroom area and the bathroom were noted to have water stains on them. 1d: An observation of room 132 occurred on 9-11-17 at 3:55pm. The ceiling tiles above the window were noted to have water stains on them. An observation of room 132 occurred on 9-13-17 at 1:50pm. The ceiling tiles above the resident's window were noted to have water stains on them. An interview with the maintenance manager occurred on 9-13-17 at 2:10pm. The maintenance manager stated he had not noted any of the ceiling tiles in the residents rooms with water steins. He stated he only checks the ceiling tiles in the hallways. The maintenance manager also stated that the ceiling tiles have not been a priority. An interview with the maintenance manager occurred on 9-13-17 at 2:10pm. The maintenance manager discussed replacing ceiling tiles in the hallways after each rain. He also stated that the roof has been leaking for as long as he had worked for the facility which he stated had been 3 years. The Maintenance manager stated he had tried to do patch repair work on the roof to stop the leaks but that he had been unsuccessful. An attempt to review the maintenance log occurred on 9-13-17 to verify the repairs however	F 253	Maintenance Director and or the Administrator and or the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers regarding requesting repairs for environmental issues. Whenever there is an issue identified, a Maintenance Request Form must be completed and in writing. Any concern/repair that may affect resident safety, the concern will be reported to the Maintenance Director and or Supervisor on Duty and or Administrator. An audit of ceiling tiles was completed in resident rooms and bathrooms by Maintenance to ensure no other stained ceiling tiles are present. Any identified stained ceiling tiles have been replaced. An audit of windows in the resident rooms was completed by Maintenance to ensure no other broken areas. Any identified broken windows have been replaced. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) will audit five resident rooms per week to ensure no ceiling tiles are stained, blinds are intact, and windows are not broken. The Administrator will present the results of the room observation audit to the center□s Quality Assurance and Performance Improvement Committee. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance	

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F 253	Continued From page 10 there were not any logs available to review. 2: An observation of room 109 occurred on 9-12-17 at 11:20am. The vertical blinds in room 109 were noted to have one broken slat that was broken in the middle preventing the blind to be shut completely. The window in room 109 was also noted to have 2 broken areas; bottom right corner and the upper right corner. Both areas were taped with clear tape. An interview with resident #78 occurred on 9-12-17 at 11:22am. The resident stated that the blind had been broken for "several" months but could not state exact time frame. The resident also stated he does not see well enough to have noticed the window being broken. An observation of room 109 occurred on 9-13-17 at 1:50pm. The blinds in room 109 were noted to be fixed however the window continued to be broken with clear tape over the broken areas. An interview with the maintenance manager occurred on 9-13-17 at 2:10pm. The maintenance manager stated that he knew about the glass in the window of room 109 being broken and that he was the one who placed clear tape over the broken areas. He was unable to state how long the glass in the window had been broken. An interview with the Administrator occurred on 9-14-17 at 1:50pm. The Administrator stated that she expected repairs that were needed be put in writing and given to the maintenance manager so he can keep a log of what was completed. She also stated that she expected repairs to be completed as soon as possible. The Administrator stated she would review the	F 253	Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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F 253	Continued From page 11 maintenance log weekly to ensure that repairs were being completed.	F 253		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 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 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).	F 279		10/12/17

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F 279	Continued From page 12 (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 section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to develop a comprehensive care plan for ADL care and incontinence care, specifically for e-stim therapy and bowel regimen for 1 of 1 residents (resident # 165). Findings include: A review of the care area assessment (CAA) dated 5-11-17 revealed that resident #165 triggered for activity of daily living (ADL) function and that he was to be care planned in this area	F 279	Resident #165 care plan did not include e-stim and bowel regimen. Resident #165 was updated to reflect ADL care being received including e-stim therapy and bowel regimen. Comprehensive care plans are to reflect the resident□s current status. Areas indicated in the Care Area Assessment to be care planned are to be care planned as indicated. Residents care plans were reviewed and updated, as needed, by the MDS Coordinator and the Interdisciplinary	

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F 279	Continued From page 13 with the goal of "independent in all activity of daily living (ADL's) and be discharged to the community by next review". A review of the care plan for resident #165 dated 8-11-17 revealed there was no care plan for ADL function and there was no goal of "independent in all activity of daily living (ADL's) and be discharged to the community by next review". A review of the care area assessment (CAA) dated 5-11-17 revealed that resident #165 triggered for incontinence and that he was to be care planned in this area for bowel and e-stim schedule with the goal of "no signs or symptoms of bowel impaction" and for staff to ensure that resident was using the e-stim in the correct manner. A review of the care plan for resident #165 dated 8-11-17 revealed there were no goals or interventions pertaining to the resident's bowel and e-stim schedule. An interview with the Minimum Data Set (MDS) nurse occurred on 9-14-17 at 12:22pm. The MDS nurse reviewed the CAA and then the care plan and stated "It should have been care planned. I made a mistake and did not do it".	F 279	Care Team Members, including the Director of Social Services, the Registered Dietician, the Director of Therapy and the Activity Director to reflect resident□s current status and ensure Care Area Assessment triggers were care planned if indicated. MDS Coordinator and Interdisciplinary Care Team Members, including the Director of Social Services, the Registered Dietician, the Director of Therapy and the Activity Director, who complete Minimum Data Set were in-serviced by the District Director of Care Management that care plan areas triggered in Care Area Assessment that are indicated to be care planned. MDS Coordinator and Interdisciplinary Team Members who complete Minimum Data Set were in-serviced that comprehensive care plan is to be reflective of resident□s current status. The District Director of Care Management will audit three Care Plans per week to validate care plans are reflective of the resident□s current status. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Administrator and or Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to	

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F 279	Continued From page 14	F 279	determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	
F 312 SS=E	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (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 reviews, observations, staff and resident interviews the facility failed to provide incontinence care for 3 of 4 residents and failed to provide showers for 1 of 4 residents. This was evident for 3 of 4 residents that were reviewed for activities of daily living (ADL's). (Resident #26, Resident # 111 and resident #113). Finding included: 1. Resident # 113 was admitted to facility on 6/30/2017 with the current diagnoses of hypertension, seizure disorder and cerebral palsy. Resident #113's admission Minimum Data Set (MDS) dated 7/7/2017 revealed the resident was cognitively intact. The resident required extensive assistance with all her ADL's except for eating. The resident was always incontinent of bladder	F 312	Per review of concern log and interviews with the surveyors Residents #26, #113, #111 stated their call bells were not answered timely. Per interview with the surveyors Residents #26, #113 and #111 were not provided care timely. Call bells are being answered timely. Timely Incontinent care is being provided as requested and or as needed. Resident #26 was not receiving showers per her request. Resident #26 preferences were updated to reflect her shower preference. Staff members are to respond to call bells in a timely manner and address the residents requests, if able, at that time. If staff is unable to meet the residents request at the time the call bell is answered the request should be met as	10/12/17

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F 312	Continued From page 15 and bowel. During an Interview with Resident # 113 on 9/12/2017 at 2PM, Resident #113 indicated that last week (September 4 through 10, 2017) she waited in her bed for 2 hours for staff to change her. She indicated that her call bell was on and NA #34 came in, cut off her call bell, and stated she would be back in a few minutes. Resident #113 stated it was an hour before the NA came back to change her. Resident #113 indicated that her buttocks was red and had a rash on it from waiting so long. Resident #113 indicated that she was admitted to the facility on 6/30/2017 and this has been an issue since her placement. Resident #113 indicated that her roommate had a clock on the wall in front of her bed and that on September 9 or 10, 2017 she waited in her urine and feces for over two hours and she believed that was how she got the rash on her bottom. Resident #113 indicated her brief was soiled a lot during the day. Resident #113 indicated this made her feel bad that staff took so long to provide care for her and that the facility did not have enough staff to provide care for the residents. Resident #113 was observed on 09/12/17 at 3:23 PM. The resident was observed during ADL care. The resident was pivoted and transferred from her wheelchair to the bed by the assistance of 1 NA. The resident's briefs were taken off and her brief had a small amount of yellow urine in it. The resident had a red rash between her legs bilaterally. The rash had red, raised bumps that extended from in between her perennial area around to her buttocks. The resident was cleaned properly and Calazine lotion was applied to the resident's rash. The resident stated during ADL	F 312	quickly as possible. Staff is to interact with residents in a respectable manner. Staff members are to provide showers per the shower schedule and as requested by the resident. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that staff is to interact with residents in a respectable manner. Nursing staff were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on providing showers per the schedule and as requested by the resident. The Department Managers (including the	

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F 312	Continued From page 16 care that "her rash was painful and itchy. That even with the cream that the area still hurts. She stated that she had kept this rash". A new brief was place on the resident as well as pants and the resident was placed back in her wheelchair with the assistance from 1 person via stand and pivot. Observation of care revealed only one staff assisting with transfer on 9/12/2017 at 3:23 PM. Resident #113 was interviewed on 9/13/2017 at 2PM. Resident #113 indicated that "I sometimes get cold when I am wet, my bottom being sore and lying in your urine and feces for a long time was not a good feeling. It makes you feel sad and alone." During an interview with NA #34 09/13/2017 at 2:30 PM she revealed she was not the NA that left Resident #113 in urine and feces last week but it was NA #43. During an Interview with NA #43 on 9/14/2017 at 10 AM, NA #43 indicated that she would never leave a resident in urine and feces for that long. She also stated she would not turn off the residents call bell without coming back in 10 to 15 minutes to provide care and treatment. During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM she stated her expectation was that all staff should answer a call bell within 3-5 minutes of the resident putting the call bell on and her expectation would be all staff provide incontinence care as so as possible. 2 a. Resident #26 was admitted to the facility on 05/17/17 with current diagnoses of chronic obstructive pulmonary disease, hypothyroism, and obstructive sleep apnea.	F 312	Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director, and the Sc8heduler) will interview ten residents per week to validate timely provision of incontinent care. The Department Managers will interview ten residents per week to validate residents are being treated in a respectable manner. The Administrator, the Department Managers, the Director of Nursing, Unit Managers and Nurse Supervisors will conduct ten random resident observations per week to validate call bells are responded to in a timely manner. The Department Managers will interview 10 residents per week to validate showers are being given per the schedule and as requested. The Administrator, the Director of Nursing, Unit Mangers and Nurse Supervisors will audit ten residents per week to validate documentation of showers being given per the shower schedule and as requested. The Administrator will present the results of the call bell audit and the Director of Nursing will present the results of the timely incontinence care audit and the shower audit to the center□s Quality Assurance and Performance Improvement Committee. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented for a minimum of three months,	

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F 312	Continued From page 17 Review of Resident #26's quarterly Minimum Data Set (MDS) dated 06/24/17, revealed that Resident #26 was cognitively intact, legally blind and able to make her needs known. The resident required limited to extensive assistance for all her activities of daily living except for toilet use for which she required limited assistance with one person physical assist. Resident #26 was continent bowel and bladder. During an interview on 09/11/17 at 6:45 PM Resident #26 revealed that during her first week on the long hall she waited 2 hours or longer to be changed. Resident #26 indicated when she put on her call bell no one answered. Resident #26 indicated that was a bad feeling waiting so long to be changed. Resident #26 indicated that this had been reported to the facility. Resident #26 added she wanted to go to another facility and hoped that staff would care for her and help her feel better about her situation. A review of the concern logs from 06/17 until present revealed that Resident #26 had concerns about her call bell not being answered in a timely manner. On 08/08/17 and 08/31/17 resident had urinated and her bed was soaked before staff answered her call bell. During an interview with the Social Worker on 09/13/17 at 2:30 PM she revealed she had moved Resident #26 on 09/06/17 to a new room. SW indicated during this interview that Resident #26 had issues with her call bell not being answered and staff not changing her. During an interview with Nursing Assistant (NA) #3 for Resident # 26 on 09/13/17 at 3:30 PM, she revealed she had only been working with	F 312	in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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Resident #26 for two days. NA #3 indicated she had not had any concerns with this resident and that she always treated her residents with respect and provided the care they needed.

During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM she stated her expectation was that all staff should answer a call bell within 3-5 minutes of the resident putting the call bell on and her expectation would be all staff provide incontinence care as so as possible.

2b. Resident #26 was admitted to the facility on 05/17/17 with current diagnoses of chronic obstructive pulmonary disease, hypothyroism, and obstructive sleep apnea.

Review of Resident #26's quarterly Minimum Data Set (MDS) dated 05/24/17, revealed that Resident #26 was cognitively intact, legally blind and able to make her needs known. The resident required limited to extensive assistance for all her activities of daily living except for toilet use for which she required limited assistance with one person physical assist. Resident #26 was continent bowel and bladder.

During an interview on 09/11/17 at 6:45 PM Resident #26 revealed that during her first week on the long hall she waited 2 hours or longer to be changed. Resident # 26 indicated when she put on her call bell no one answered. Resident #26 indicated that was a bad feeling waiting so long to be changed. During this same interview Resident #26 indicated that she had not had a shower in two weeks until today 09/11/17.

During an interview with the Social Worker on 09/13/17 at 2:30 PM she confirmed what

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Resident #26 stated during her interview on 09/11/17. The SW indicated that that was why Resident #26 had moved on 09/06/17 to a new room. SW indicated during this interview that Resident #26 had issues with her call bell not being answered and staff not changing her.
A review of the point of care audit report on 09/13/17 at 2 PM provided by the DON revealed there was no indication that Resident #26 had been given a shower during the past two weeks. Resident # 26's name was not on the point of care audit report.

During an interview with the DON on 09/13/17 at 3:30 PM she indicated that her expectation would be that all residents had weekly showers.

3. Resident #111 was admitted to facility on 8/05/2015 with the current diagnoses of hypertension, diabetes mellitus and hyperlipidemia.

Resident #111's quarterly Minimum Data Set (MDS) dated 8/30/2017 revealed the resident was cognitively intact. The resident required extensive assistance with all her Activities of daily living (ADL) except for eating. The resident was always incontinent of bladder and bowel.

During an interview with Resident # 111 on 9/12/2017 at 1:30 PM, she indicated the week of August 5, 2017 through August 12, 2017 she waited in her bed for 2 hours for staff to change her. She indicated that her call bell was on and Nursing Assistant #34 came in, cut off the call bell, and stated she would be back in a few minutes but it was an hour before she came back. Resident #111 indicated that her buttocks was red and she had a rash from waiting so long.

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Resident #111 also revealed that this had happened several time during her stay. Resident #111 indicated that she had a clock on the wall in front of her bed and that was how she knew how long she waited for staff to answer her call bell. Resident # 111 revealed that on September 9 or 10, 2017 she waited in her urine and feces for over two hours, and she believed that incident caused her red bottom. Resident #111 indicated that this made her feel bad that staff took so long to provide care for her. Resident # 111 indicated that the facility did not have enough staff to provide care for the residents.
During a second interview with Resident #111 on 9/13/2017 at 2:10 PM she indicated that she felt terrible about her condition of being wet and dirty on September 9 or 10, 2017. She stated her bottom was sore and it was not a great feeling lying in her urine and feces for a long time.

During an interview with Nursing Assistant (NA) #34 on 9/13/2017 at 2:45 PM, she stated she was not the NA that left Resident # 111 in her urine and feces the previous week but it was NA #43.

During an Interview with NA #43 on 9/14/2017 at 10AM, NA #43 indicated that she would never leave a resident in urine and feces for that long. She also stated that she would not cut off a residents call bell without coming back in 10 to 15 minutes.

During an interview with Director of Nursing (DON) on September 13, 2017 at 3:45 PM she stated her expectation was that all staff should answer a call bell within 3-5 minutes of the resident putting the call bell on and her expectation would be all staff provide incontinence care as so as possible.

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F 322 SS=E	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations the facility failed check the placement of a gastrostomy feeding tube before administrating medications for 2 of 4 resident's with feeding tubes (Resident 92, resident #122). Findings included: The facility's policy for enteral nutrition dated 2/2017 stated that nurse should check gastrostomy tube placement prior to intermittent feedings and periodically during continuous feeding and prior to flushed and/or medication	F 322	Per observation by surveyor on 9/13/17, Residents #92 and #122 did not have their gastrostomy tubes checked for placement per procedure. Residents #92 and #122 did not have any adverse effects from not checking the gastrostomy feeding tube placement checked prior to medication administration. Residents #92 and #122 are currently having the placement checked prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. Licensed Nurse #2 was	10/12/17

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F 322	Continued From page 22 administration. 1. Resident #92 was admitted on 4/24/17 with the diagnosis of a stroke, hypertension and malnutrition. Resident #92 had a Gastrostomy tube (G tube). A gastrostomy tube is a tube that is inserted through the abdomen that delivers nutrition directly to the stomach. Resident #92 had orders dated 11/18/16 to give 30 ml of free water via Gastrostomy tube before and after medication administration and 5 ml of free water between each medication every shift. Resident's #92 Quarterly Minimum Data Set (MDS) dated 7/19/17 revealed that the resident was rarely understood. The resident had weight gain of 5% or more and had a feeding tube. The resident received 51% or more of total calories through tube feedings. Resident #92 medication orders revealed the following medications were ordered for 9/2017: Verapamil HCL 40 mg via G tube every 12 hours Docusate Sodium liquid 10 ml via G tube two times a day Baclofen tablet 20mg via G tube four times a day Decubi-vite capsule 1 capsule one time a day During medication administration observation on 9/13/17at 8:23 AM. Verapamil, Docusate Sodium, baclofen were all crushed and Decubi-vits capsule contents were opened up. All medications were divided into individual cups and mixed with 15ml of water. Nurse #2 did not confirm placement of the feeding tube before	F 322	provided a one to one competency in-service by the Staff Development Coordinator. Gastrostomy tubes are to be checked for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. Residents with gastrostomy tubes have been identified and are currently having the placement checked prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. Licensed Nurses were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that gastrostomy tubes are to be checked for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. The Staff Development Coordinator and or the Director of Nursing and or the Unit Managers will observe five resident gastrostomy tubes checks for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. The results of the audits will be presented by the Director of Nursing to the center□s Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of	

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F 322	Continued From page 23 administrating medications. Nurse #2 did not flush the resident's G tube before pouring the medication in the G tube. After pouring in the first medication, the medication would not go into the tube and the medication was stuck in the syringe. The nurse dumped the medication back out of the feeding tube and poured 30 ml of water down the G tube. Then she proceeded to dump each medication into the G tube without flushing in between each medication. After each medication was administered, she flushed the G tube with 30 ml of water. Nurse #2 interviewed on 9/13/16 at 2:30 PM. She would check the placement of the feeding tube, make sure there was no residual and then would give the medication. She would flush before and after the medications. She stated that she would usually listen for the "swoosh" sound when auscultating the feeding tube. She stated that she knew her mistakes and stated that she was nervous when administrating the medications. The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated that a medication pass observation was completed on Tuesday of this week at the facility by the pharmacy. He stated that he would expect that the feeding tube was flushed before and after medications were given through a feeding tube and for the placement of the feeding tube was checked according to the facility's policy. The Director of Nursing (DON) was interviewed on 9/14/17 at 2:57 PM. She stated that she would expect that placement of the feeding tube would be checked before giving medications and that the feeding tube was flushed.	F 322	twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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F 322	Continued From page 24	F 322		

2. Resident #122 was admitted on 6/30/15 with the diagnoses of a mood disorder, malnutrition and dementia.

Resident #122 had a Gastrostomy tube (G tube). A gastrostomy tube is a tube that is inserted through the abdomen that delivers nutrition directly to the stomach.

The resident had the following order dated 11/18/16 to verify placement of G tube via auscultation with stethoscope and aspiration of stomach contents each shift per protocol.

Resident's Minimal Data Set (MDS) dated 8/7/17 revealed the resident was severely cognitively impaired. The resident did not have any weight loss or gain and had a feeding tube. The resident received 51% or more of total calories through tube feedings.

Resident #122 had the following medication orders for 9/2017:

Ziprasidone 20mg capsule twice a day via G tube
Metoprolol Tartrate 25mg via G tube twice a day
Valproic Acid liquid 10 ml via G tube twice a day

Nurse #2 was observed during medication administration on 9/13/17 at 8:40 AM. Nurse #2 crushed Metoprolol medication and opened up the Ziprasidone capsules. She separated each medication into its own cup. She mixed each medication with 15 ml of water. She did not check placement of the feeding tube prior to administration and administered medications via the G tube without flushing the G tube before or in between each medication. After all medications were given, nurse #2 flushed the feeding tube

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F 322	Continued From page 25 with water. Nurse #2 interviewed on 9/13/16 at 2:30 PM. She would check the placement of the feeding tube, make sure there was no residual and then would give the medication. She would flush before and after the medications. She stated that she would usually listen for the "swoosh" sound when auscultating the feeding tube. She stated that she knew her mistakes and stated that she was nervous when administrating the medications. The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated that a medication pass observation was completed on Tuesday of this week at the facility by the pharmacy. He stated that he would expect that the feeding tube be flushed before and after medications were given through a feeding tube and for the placement of the feeding tube was checked according to the facility's policy. The Director of Nursing was interviewed on 9/14/17 at 2:57 PM. She stated that she would expect that placement that tube would be checked before giving medications and that the feeding tube was flushed.	F 322		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (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	F 323		10/12/17

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F 323	Continued From page 26 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, record reviews, staff and resident interviews the facility failed to provide two staff for transfer a resident to the bed for incontinence care and the facility failed to provide supervision to prevent repeated falls for 1 of 3 residents (Resident #113) sampled residents reviewed for accidents. Findings include: 1 a. Resident # 113 was admitted to facility on 6/30/2017 with the current diagnoses of hypertension, seizure disorder and cerebral palsy. Resident #113 Minimum Data Set (MDS) dated 7/7/2017 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility, transfers, toilet use with two person physical assist and with locomotion,	F 323	On 9/12/17 NA#13 transferred Resident #113 with one person assistance. Resident #133 is care planned for assistance of 2 staff members. NA#13 stated she transferred Resident #113 per one person assistance because the state wanted to observe the care and she would normally would get help for this resident. There were no complications noted from Resident #113 being transferred via the assistance of one Certified Nursing Assistant on 9/12/17. Resident #113 is currently being transferred with the assistance of two staff members. NA #13 was provided a one to one in-service by the Staff Development Coordinator regarding transferring residents per their care plan. Resident #113 call bell is being responded to timely. Resident #113 care	

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F 323	Continued From page 27 dressing, and personal hygiene need extensive assistance with one person physical assist. Resident total dependence on staff for bathing. The resident was incontinent of bladder and incontinent of bowel. Resident #113 needs two person physical assist at all times. During an Interview with Resident # 113 on 9/12/2017 at 2PM, Resident # 113 indicated that she was admitted to the facility on 6/30/2017 and staffing has been an issue since her placement. Resident #113 also revealed she had several falls because staff did not respond to the call bell. Resident # 113 indicated that her roommate has a clock on the wall in front of her bed. Resident # 113 indicated that that was how she knew how long she waited for staff to answer her call bell. Resident # 113 indicated that the facility does not have enough staff to provide care for the residents. Resident #113 revealed that this is why" I feel sad and down a lot around this place because staff are so slow and their attitudes are not the greatest but she has to get better so she can go home." Resident #113 was observed on 9/12/17 at 3:23 PM. The resident was observed during ADL care. The resident was pivoted and transferred from her wheelchair to the bed by the assistance of 1 NA. The resident's briefs were taken off and her brief had a small amount of yellow urine in it. The resident had a red rash between her legs bilaterally. The rash had red, raised bumped that extended from in between her perineal area around to buttock. The resident was cleaned properly and Calazine lotion was applied to the resident's rash. The resident stated during ADL care that "her rash was painful and itchy. That even with the cream that the area still hurts. She	F 323	plan interventions related to falls prevention are being followed in an effort to prevent further falls. Transfers are to be performed per the plan of care. Staff is to follow falls prevention care plans. The Director of Nursing, Staff Development Coordinator, Unit Managers and or Nurse Supervisors will interview alert and orient residents post fall to assist in determining the root cause of the fall, then will address it accordingly and implement measures to assist in falls prevention. Nursing Staff members were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that transfers are to be performed per the plan of care and falls prevention care plans are to be followed. The Staff Development Coordinator and or the Director of Nursing and or the Unit Managers will observe five resident transfers per week to validate compliance with the care plan. The Staff Development Coordinator and or the Director of Nursing and or Unit Managers and or Nurse Supervisor will interview alert and oriented residents post fall to assist in determining the root cause; then they will address it accordingly and implement measures to assist in falls prevention. The Director of Nursing will present the results of the transfer audits as well as any trends from the resident interviews to the Quality Assurance and Performance Improvement Committee for	

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F 323	Continued From page 28 stated that she has kept this rash". A new brief was place on the resident as well as pants and the resident was placed back in her wheelchair with the assistance from 1 person via stand and pivot. Observation of care revealed only one staff assisting with transfer on 9/12/2017 at 3:23 PM. During an interview on 9/13/2017 at 3:30PM with the Nursing Assistant #13 (NA) who performed the ADL care on Resident #113, indicated she completed care on Resident because the state wanted to observed Resident #113 but she normally would get help for this resident. During an interview with Director of nursing on 9-14-17 3:30PM, stated she expected staff to follow the care guide/care plan and have 2 staff present to transfer the resident. During an interview with the Interview with Administrator on 9-14-17 at 3:30PM, she indicated her expectations for falls was that the team would meet (DON, Admin, MDS, nurse manager for unit) to evaluate why the falls were occurring, decide on interventions that would be appropriate. b. Resident # 113 was admitted to facility on 6/30/2017 with the current diagnoses of hypertension, seizure disorder and cerebral palsy. Resident #113 Minimum Data Set (MDS) dated 7/7/2017 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility, transfers, toilet use with two person physical assist and with locomotion, dressing, and personal hygiene need extensive assistance with one person physical assist. Resident total dependence on staff for bathing.	F 323	review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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The resident was incontinent of bladder and incontinent of bowel. Resident #113 needs two person physical assist at all times.

During an Interview with Resident # 113 on 9/12/2017 at 2PM, Resident # 113 indicated that she was admitted to the facility on 6/30/2017 and staffing has been an issue since her placement. Resident #113 also revealed she had several falls because staff did not respond to the call bell. Resident # 113 indicated that her roommate has a clock on the wall in front of her bed. Resident # 113 indicated that that was how she knew how long she waited for staff to answer her call bell. Resident # 113 indicated that the facility does not have enough staff to provide care for her.

Review of the incident/accident report dated 7/10/2017 was reviewed on 9/13/2017 at 11AM, revealed that "Called to room by NA noted resident to be lying in floor face down. Resident stated she bent over in her wheelchair to get her spoon she dropped on the floor. When she bent over she fell out of her wheelchair."

During an interview with Resident #113 on 9/13/2017 at 1:45PM, she revealed that she had dropped her spoon and it took staff about 45 minutes to come to help her.

Review of incident/accident report dated 8/8/2017was reviewed on 9/13/2017 at 11AM that revealed "Nursing Assistance reported. Resident slid to floor. No injury.

During an interview with Resident #113 on 9/13/2017 at 1:45PM, she revealed that the NA was the only staff providing care for her during that incident.

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F 323	Continued From page 30 Review of incident/accident report dated 8/13/2017 on 9/13/2017 at 11AM that revealed "Resident found on the floor with back up against the door. Patient in a sitting position. States she was trying to go to the bathroom." During an interview with NA #5 on 9-14-17 at 2PM, she indicated that Resident #113 falls were intentional because the resident wanted attention. Stated she felt the resident wanted to be independent in going to the bathroom and getting her own things but cannot be independent. Stated no one was present for the falls and that the resident knew to press the call light. During an interview with Director of nursing on 9-14-17 3:30PM, stated she expected staff to follow the care guide/care plan and have 2 staff present to transfer the resident. During an interview with Administrator on 9-14-17 at 3:30PM, she indicated her expectations for falls was that the team would meet (DON, Admin, MDS, nurse manager for unit) to evaluate why the falls were occurring, decide on interventions that would be appropriate.	F 323		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (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:	F 332		10/12/17

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F 332	Continued From page 31 Based on record review, staff interviews and observations the facility failed to have a medication error rate less than 5%, as evidenced by 3 medication errors out of 25 opportunities, resulting in a medication error rate of 12% for 2 of 7 residents observed for medication pass (Resident 92, resident #122). Findings included: The facility's policy for enteral nutrition dated 2/2017 stated that the nurse should irrigate the feeding tube with 30 to 60 milliliters (ml) of tap water before and after administration of medications and 5 to 10 ml in-between administration of multiple medications (or as ordered by the physician), before initiating a feeding or when there is an interruption of feeding. 1. Resident #92 had a Gastrostomy tube (G tube). A gastrostomy tube is a tube that is inserted through the abdomen that delivers nutrition directly to the stomach. Resident #92 had orders dated 11/18/16 to give 30 ml of free water via Gastrostomy tube before and after medication administration and 5 ml of free water between each medication every shift. Resident #92 medication orders revealed the following medications were ordered for 9/2017: Verapamil HCL 40 mg via G tube every 12 hours Docusate Sodium liquid 10 ml via G tube two times a day Baclofen tablet 20mg via G tube four times a day Decubi-vite capsule 1 capsule one time a day a. During medication administration observation on 9/13/17at 8:23 AM. Verapamil, Docusate Sodium, baclofen were all crushed and Decubi-vits capsule contents were opened up. All medications were divided into individual cups and mixed with 15ml of water. Nurse #2 did not confirm placement of the feeding tube before	F 332	Per observation by surveyor on 9/13/17, Residents #92 and #122 did not have their gastrostomy tubes checked for placement per procedure. Residents #92 and #122 did not have any adverse effects from not checking the gastrostomy feeding tube placement checked prior to medication administration. Residents #92 and #122 are currently receiving their medications and water flushes per physician□s order and center policy. Residents #92 and #122 are currently having the placement checked prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. Residents #92 and #122 are currently having their gastrostomy tubes irrigated with 30 to 60 ml of water before and after administration of medications and 5 to 10 ml in between administration of multiple medications or as ordered by the physician before initiating a feeding or when there is an interruption of feeding. Licensed Nurse #2 was provided a one to one competency in-service by the Staff Development Coordinator. Gastrostomy tubes are to be checked for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration. Medications are to be administered per physician□s order and center policy. Residents with gastrostomy tubes have been identified and are currently having the placement checked prior to intermittent feedings and periodically during continuous feedings	

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F 332	Continued From page 32 administrating medications. Nurse #2 did not flush the resident's G tube before pouring the medication in the G tube. After pouring in the first mediation, the medication would not go into the tube and the medication was stuck in the syringe. The nurse dumped the medication back out of the feeding tube and poured 30 ml of water down the G tube. Then she proceeded to dump each medication into the G tube without flushing in between each medication. After each medication was administered, she flushed the G tube with 30 ml of water. Nurse #2 interviewed on 9/13/16 at 2:30 PM. She stated that she would pull the medications from the medication cart, crush all the medication individually and make sure that they were placed in their own cup. She stated that she would also wash her hands, put on gloves, and add water to each medication before giving via the G tube. She would check the placement of the feeding tube, make sure there was no residual and then would give the medication. She would flush before and after the medications. She stated that she would usually listen for the "swoosh" sound when auscultating the feeding tube. She stated that she knew her mistakes and stated that she was nervous when administrating the medications. The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated that a medication pass observation was completed on Tuesday of this week at the facility by the pharmacy. He stated that he would expect that the feeding tube was flushed before and after medications were given through a feeding tube and for the placement of the feeding tube was checked according to the facility's policy. The Director of Nursing (DON) was interviewed on 9/14/17 at 2:57 PM. She stated that she would	F 332	and prior to flushes and or medication administration. Residents with gastrostomy tubes are to have their gastrostomy tubes irrigated with 30 to 60 ml of water before and after administration of medications and 5 to 10 ml in between administration of multiple medications or as ordered by the physician before initiating a feeding or when there is an interruption of feeding. Licensed Nurses were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that gastrostomy tubes are to be checked for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration and that residents with gastrostomy tubes are to have their gastrostomy tubes irrigated with 30 to 60 ml of water before and after administration of medications and 5 to 10 ml in between administration of multiple medications or as ordered by the physician before initiating a feeding or when there is an interruption of feeding. The Staff Development Coordinator and or the Director of Nursing and or the Unit Managers will observe five resident gastrostomy tubes checks for placement prior to intermittent feedings and periodically during continuous feedings and prior to flushes and or medication administration and that residents with gastrostomy tubes are to have their gastrostomy tubes irrigated with 30 to 60 ml of water before and after	

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F 332	Continued From page 33 expect that placement of the feeding tube would be checked before giving medications and that the feeding tube was flushed. b. During medication administration observation on 9/13/17 8:23 AM, nurse #2 was observed to remove Docusate Sodium 100 mg tablet from the medication cart, crush the tablet and mix it with 15 ml of water. The medication was administrated to resident #92 via the G tube. Physician's orders revealed resident #92 had orders (9/2017) for 10 ml of Docusate Sodium in liquid form to be given. Nurse #2 interviewed on 9/13/16 at 2:30 PM. She stated that the Docusate Sodium should have been switched from the liquid form to the tablet form in the order since they don't have liquid docusate sodium. The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated the pharmacy does not typically supply the facility with over the counter stocked medication, this would include the Docusate Sodium, unless there was an exception. The DON was interviewed on 9/14/17 at 2:57 PM. She stated that she would expect for medications in the appropriate ordered form were given to the resident. 2. Resident #122 had a Gastrostomy tube (G tube). A gastrostomy tube is a tube that is inserted through the abdomen that delivers nutrition directly to the stomach. Resident #122 had the following medication orders for 9/2017: Ziprasidone 20mg capsule twice a day via G tube Metoprolol Tartrate 25mg via G tube twice a day Valproic Acid liquid 10 ml via G tube twice a day Nurse #2 was observed during medication administration on 9/13/17 at 8:40 AM. Nurse #2 crushed Metoprolol medication and opened up	F 332	administration of medications and 5 to 10 ml in between administration of multiple medications or as ordered by the physician before initiating a feeding or when there is an interruption of feeding. The results of the audits will be presented by the Director of Nursing to the center□s Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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F 332	Continued From page 34	F 332		

the Ziprasidone capsules. She separated each medication into its own cup. She mixed each medication with 15 ml of water. She did not check placement of the feeding tube prior to administration and administered medications via the G tube without flushing the G tube before or in between each mediation. After all medications were given, nurse #2 flushed the feeding tube with water.

Nurse #2 interviewed on 9/13/16 at 2:30 PM. She stated that she would pull the medications from the medication cart, crush all the medication individually and make sure that they were placed in their own cup. She stated that she would also wash her hands, put on gloves, and add water to each medication before giving via the G tube. She would check the placement of the feeding tube, make sure there was no residual and then would give the medication. She would flush before and after the medications. She stated that she would usually listen for the "swoosh" sound when auscultating the feeding tube. She stated that she knew her mistakes and stated that she was nervous when administrating the medications.

The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated that a medication pass observation was completed on Tuesday of this week at the facility by the pharmacy. He stated that he would expect that the feeding tube be flushed before and after medications were given through a feeding tube and for the placement of the feeding tube was checked according to the facility's policy.

The Director of Nursing was interviewed on 9/14/17 at 2:57 PM. She stated that she would expect that placement of the feeding tube would be checked before giving medications and that the feeding tube was flushed.

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F 353 SS=E	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services 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	F 353		10/12/17

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F 353	Continued From page 36 nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and 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 reviews, interviews with staff, resident and families and observations the facility failed to provide staffing of sufficient quantity and quality to provide incontinence care, toileting, choices, answer call bells and supervision to prevent accidents for residents who required assistance. This affected 4 out of 40 residents (Resident #26, Resident #111, Resident #113 and Resident #135). This tag is cross referenced to tags F241, F242, F312 and F323. Finding included: F 241: Based on observations, record reviews, resident and staff interviews the facility failed to provide incontinence care when requested, resulting in compromised dignity for 3 of 4 residents who required extensive assistance with personal hygiene. This was evident for 3 of 4 residents (Resident # 26, Resident #113, and Resident #111 F242: Based on observation, staff and resident interviews the facility failed to honor a resident ' s choice to get out of bed early for 1 of 3 residents reviewed for choices (Resident #135.) F312: : Based on record reviews, observations,	F 353	Per review of concern log and interviews with the surveyors Residents #26, #113, #111 stated their call bells were not answered timely. Per interview with the surveyors Residents #26, #113 and #111 were not provided care timely. Call bells are being answered timely. Timely Incontinent care is being provided as requested and or as needed. Staff has been educated regarding timely completion of their assigned duties in order to anticipate and meet resident needs timely. Residents #26, #113 and #111 call bells are being answered timely. Incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. Resident #135 is currently going to and getting up from bed per her choice. Residents #26, #113 and #111 call bells are being answered timely. Incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. Resident #135 requested to the Social Worker get up early. The Social Worker forgot to notify nursing staff resulting in Resident #135	

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F 353	Continued From page 37 staff and resident interviews the facility failed to provide incontinence care for 3 of 4 residents and failed to provide showers for 1 of 4 residents. This was evident for 3 of 4 residents that were reviewed for activities of daily living (ADL ' s). (Resident #26, Resident # 111 and Resident #113). F323: Based on observations, record reviews, staff and resident interviews the facility failed to provide two staff for transfer a resident to the bed for incontinence care and the facility failed to provide supervision to prevent repeated falls for 1 of 3 residents (Resident #113) sampled residents reviewed for accidents. During an interview with Director of Nursing (DON) on 09/13/17 at 3:45 PM, she indicated that her expectations for all staff to answer a call bell within 3-5 minutes. Her expectation would be that all staff treat all residents with respect and dignity. During an interview with Administrator on 09/14/17 at 1:30pm, her expectations for staffing was that there would be enough staff on duty to attend to the residents needs in a timely fashion. Timely was answering call lights within 5minutes.	F 353	staying in bed longer than her preference. Resident #135 Care Plan was updated per her preference. Resident #135 is currently going to and getting up from bed per her choice. There were no complications noted from Resident #113 being transferred via the assistance of one Certified Nursing Assistant on 9/12/17. Resident #113 is currently being transferred with the assistance of two staff members. NA #13 was provided a one to one in-service by the Staff Development Coordinator regarding transferring residents per their care plan. Resident #113 call bell is being responded to timely. Resident #113 care plan interventions related to falls prevention are being followed in an effort to prevent further falls. Staff members are to respond to call bells in a timely manner and address the residents requests, if able, at that time. If staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff is to interact with residents in a respectable manner. Staff members are to honor resident preferences for time of going to and getting out of bed. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) interviewed alert and oriented residents to determine residents choices for time of going to and getting out of bed. The Department	

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F 353	Continued From page 38	F 353	Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) interviewed family members, where available, for residents who are not alert and oriented, to determine resident times for going to and getting out of bed. Staff members are to respond to call bells in a timely manner and address the residents requests, if able, at that time. If staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff is to interact with residents in a respectable manner. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that staff is to interact with residents in a respectable manner. Nursing staff were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that incontinent care is being	

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F 353	Continued From page 39	F 353	provided as requested with incontinent checks being provided approximately every two hours and or as needed. Staff members are to provide showers per the shower schedule and as requested by the resident. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on providing showers per the schedule and as requested by the resident. Transfers are to be performed per the plan of care. Staff is to follow falls prevention care plans. Director of Nursing, Staff Development Coordinator, Unit Managers and or Nurse Supervisors will interview alert and orient residents post fall to assist in determining the root cause of the fall, then will address it accordingly and implement measures to assist in falls prevention. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on answering call bells in a timely manner and meeting the request if able. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that if staff is unable to meet the residents request at the time the call bell is answered the request should be met as quickly as possible. Staff members were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that staff is to	

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F 353	Continued From page 40	F 353	interact with residents in a respectable manner. Nursing staff were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that incontinent care is being provided as requested with incontinent checks being provided approximately every two hours and or as needed. Nursing staff were in-serviced by the by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on honoring resident preferences for time of going to and getting out of bed and honoring resident choices. Nursing staff were in-serviced by the Administrator and or Staff Development Coordinator and or the Director of Nursing and or the Unit Managers on providing showers per the schedule and as requested by the resident. Nursing Staff members were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers that transfers are to be performed per the plan of care and falls prevention care plans are to be followed. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) will interview ten residents per week to validate timely provision of incontinent care. The Administrator, the Director of Nursing, the Department Managers , Unit Managers and Nurse	

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F 353	Continued From page 41	F 353	Supervisors will conduct ten random resident observations per week to validate call bells are responded to in a timely manner. The Department Managers will interview ten residents per week to validate residents are being treated in a respectable manner. The Administrator will present the results of the call bell audit and the Director of Nursing will present the results of the timely incontinence care audit to the center□s Quality Assurance and Performance Improvement Committee. The Department Managers (including the Administrator, the Director of Nursing, the Business Office Manager, the Maintenance Director, the Activities Director, the Social Services Director and the Scheduler) will interview ten residents per week to validate residents choices for going to and getting out of bed times are being honored. The audits will be presented by the Director of Social Services monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting. The Department Managers will interview ten residents per week to validate showers are being given per the schedule and as requested. The Administrator, the Director of Nursing, Unit Mangers and Nurse Supervisors will audit ten residents per week to validate documentation of showers being given per the shower schedule and as requested. The Director of Nursing will present the results of the shower audits as well as any trends from the resident interviews to the Quality Assurance and Performance Improvement Committee for	

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F 353	Continued From page 42	F 353	review and recommendation. The Staff Development Coordinator and or the Director of Nursing and or the Unit Managers will observe five resident transfers per week to validate compliance with the care plan. The Staff Development Coordinator and or the Director of Nursing and or Unit Managers and or Nurse Supervisor will interview alert and oriented residents post fall to assist in determining the root cause; then they will address it accordingly and implement measures to assist in falls prevention. The Director of Nursing will present the results of the transfer audits as well as any trends from the resident interviews to the Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) 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	F 431		10/12/17

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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.

(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

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F 431	Continued From page 44 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: Based on record review, staff interviews and observations the facility failed to store medications according to the manufactures instructions and failed to discard of expired medications for 2 of 2 medication rooms and for 1 of 4 medication carts (100 medication room, 200 medication room and 200 north medication cart). Findings included: 1. Manufactures Instructions dated 6/2013 for 500 Milligrams (mg) of Metronidazole injection resulting in a concentration of 5mg/milliliter (ml) stated "do not refrigerate neutralized solutions, otherwise precipitation may occur." The 200 medication central storage room was observed on 9/14/17 at 10:30 AM and revealed the following: a. A 500 milligrams (mg) bag of Metronidazole for injection (5mg/ml) had an expiration date of 1/25/17 and was stored in the refrigerator. The back of the injection bag stated "do not refrigerate". b. There were 2 Intravenous medicine balls (a reinforced bag of medication) of Nafcillin 2 grams (gm) in Normal saline (NS) stored in the refrigerator with an expired date of 7/11/17.	F 431	On 9/14/17 per the surveyor□s and Unit Managers□ observations medications were not stored per manufacturer□s instructions and failed to discard expired medications in two of two medication rooms and for one of four medication carts. Medications are currently being stored according to the manufacturer□s instructions. There are currently no expired medications in the medication rooms or on the medication carts. Medication Carts and Medication Storage Rooms have been audited to ensure medications are stored per manufacturer□s instructions and that medications are not expired. Prior to administration Licensed Nurses are to verify medication expiration dates and that medication are stored per manufacturer□s instructions. Licensed Nurses were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers and or the Nurse Supervisor on verification of medication expiration dates and to store medications per manufacturer□s instructions. The Director of Nursing, Unit Managers	

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F 431	Continued From page 45 c. There was one intravenous medicine ball of Solumedrol 60 mg in NS stored in the refrigerator with an expiration date of 2/4/17. 2.) The 200 medication central storage room was observed on 9/14/17 at 10:30 AM and revealed the following: a. One Pneumococcal Vaccine Polyvalent 0.5 (ml) vile was stored in the refrigerator and had an expiration date of 4/30/17. b. 6 intravenous medicine balls of Ancef 2 gms in NS were stored in the refrigerator with an expiration date of 8/2/17. c. 1 bag of 20 milliequivalents (meq) of Potassium Chloride in 5% dextrose and 0.45% normal saline injection had an expiration date of 6/2017. d. 2 bags of 5% Dextrose for injection had an expiration date of 6/2017. e. 2 boxes of Influenza Vaccine Fluzone high dose 0.5 milliliters (ml) with 10 syringes in each box had an expiration date of 4/1/17 (20 syringes total). 3.) The Package insert for Xalatan (Latanoprost) ophthalmic solution dated 08/2011 stated to store unopened bottle in the refrigerator at 36 to 46 degrees Fahrenheit. Once the bottle is opened, it can be stored at room temperature for 6 weeks. a. The 200 North medication cart revealed on 9/14/17 at 2:35 PM that a bottle of Latanoprost ophthalmic solution 0.005% with an expiration date of 8/27/18 was unopened and stored on the medication cart at room temperature. The plastic bag the bottle was in had a sticker on it, which stated to keep in the refrigerator.	F 431	and Nurse Supervisors will conduct a random observation audit of one medication cart and one medication room per week to validate medications are currently being stored according to the manufacturer□s instructions and no expired medications. The Director of Nursing will present the results of the audits to the Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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F 431	Continued From page 46 The Unit manager was interviewed on 9/14/17 at 11:00 AM. She stated that the pharmacy came in at least 3 times a week and would check the medication rooms and would stock the automatic medication dispensing machine. She stated that some of the medications that were found expired in the medications room were for residents that had been discharged. She stated she thought the night shift nurses were responsible for checking for expired medications. The consultant pharmacist was interviewed on 9/14/17 at 1:33 PM. He stated that he would check the medication carts and make observations of medication administration at the facility. In the last 2 months, there were concerns about medication storage and medication administration. He stated the August, 2017 pharmacy report revealed the staff were not pulling discontinued medication from the medication carts. He stated the pharmacy checked the medication carts and medication rooms quarterly. The Director of Nursing was interviewed on 9/14/17 at 2:57 PM. She stated that she would expect for medications to be stored properly. She stated that the staff was to destroy medications in a special type of solution when a medication expired, or if a resident was discharged. She stated the administrative staff were trying to figure out a better way for this to be completed because the nurses were so busy.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		10/12/17

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(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);

(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

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F 441	Continued From page 48 (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 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 observation, record review and staff interviews the facility failed to fully implement contact precautions as ordered by the physician for 1 of 1 resident who required contact precautions due to extended spectrum beta (ß) lactamase (ESBL) infection of the urine (Resident #7.) Findings Included: The facility policy titled multi-drug resistant organisms (MDROS) dated 2012 was provided by the Director of Nursing (DON). Section II titled	F 441	Resident #7 was not placed on contact precautions when ESBL was identified by the laboratory. Resident #7 contact precautions were implemented on 9/11/17. Resident #7 was being treated for ESBL in the urine. Contact Isolation is initiated by the Licensed Nurse at the time the abnormal laboratory result is received by the center. A physician□s order is not necessary to initiate contact isolation. At the time contact isolation is initiated, appropriate	

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isolation precautions stated "Contact Precautions shall be considered for residents infected or colonized with an MDRO. A case by case decision will be made." Section titled note stated "Other organisms, not as well-known are capable of causing severe infection and death in infected individuals, especially the immunocompromised host. These include extended spectrum beta-lactamase producers."

Resident #7 was admitted to the facility on 8/23/17 and diagnoses included septicemia, urinary retention, diabetes and heart failure.

An admission minimum data set (MDS) dated 8/30/17 for Resident #7 revealed she had a indwelling Foley catheter for urine elimination, required extensive assistance with her activities of daily living (ADL ' s) and had not received any antibiotics during the 7 day look back period.

A review of the urinalysis dated 9/9/17 at 6:57 am for Resident #7 identified a urinary tract infection (UTI) was present with >100,000 colony forming units per milliliter (CFU/ml) lactose fermenting gram negative rods. The isolate was an ESBL producing microorganism.

A review of the physician orders for Resident #7 revealed an order on 9/9/17 for Nitrofurantoin Macro crystal (an antibiotic) 100 milligrams (mg) 1 tab every 12 hours for 7 days. On 9/11/17 an order to administer Invanz 1 gram (gm) intramuscular (IM) for 10 days for ESBL urinary tract infection (UTI) and an order for contact isolation for ESBL UTI until antibiotic completed.

An observation on 9/11/17 at 12:54 pm of Resident #7 ' s room revealed a contact isolation

signage should be placed on the resident□s door and the appropriate Personal Protective Equipment should be made readily available outside the resident□s door. Licensed Nurses should communicate in shift to shift report if there are any residents on Isolation Precautions.

Licensed Nurses were in-serviced by the Staff Development Coordinator and or the Director of Nursing and or the Unit Managers and or the Nurse Supervisor that Contact Isolation is initiated by the Licensed Nurse at the time the abnormal laboratory result is received by the center; a physician□s order is not necessary to initiate contact isolation; at the time contact isolation is initiated, appropriate signage should be placed on the resident□s door and the appropriate Personal Protective Equipment should be made readily available outside the resident□s door.

The Director of Nursing, Unit Managers and Nurse Supervisors will conduct a random observation of residents who are on isolation precautions once weekly to validate the signage is posted and personal protective equipment is readily available outside the resident□s door. The Director of Nursing will present the results of the audits to the Quality Assurance and Performance Improvement Committee for review and recommendation. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality

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F 441	Continued From page 50 sign was on the door to her room. There was no personal protective equipment (PPE) available outside of the resident ' s room. An observation on 9/11/17 at 3:19 pm of Resident #7 ' s room revealed a contact isolation sign was on the door to her room. There was no PPE available. A staff member was observed in the resident ' s room wearing gloves, but no other PPE. The staff member was interviewed when she left Resident #7 ' s room on 9/11/17 at 3:19 pm. She identified herself as the certified occupational therapy assistant (COTA #1). She stated she had seen the contact isolation sign on the door and had asked the nurse about it but the nurse didn ' t know why the sign was on the door. She added that she did put on gloves while working with the resident and washed her hands in the resident ' s room, but did not use any other PPE because there was none outside of her room. An observation on 9/12/17 at 4:20 pm of Resident #7 ' s room revealed a contact isolation sign was on the door to her room and PPE supplies were available in a cart in front of the resident ' s room. Red barrels were located inside of the resident ' s room. An interview on 9/12/2017 at 4:21 pm with Nursing Assistant #1 (NA) revealed that the resident was on isolation but she did not know why. She stated this was the first time she had worked with the resident and she had worn gloves and a gown when working with her. NA #1 added that when she started her shift the nurse or other NAs would tell them if there was anything special going on with the residents.	F 441	Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Director of Nursing monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing. The Administrator is ultimately responsible for the plan of correction and ensuring compliance ongoing.	

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An interview on 9/12/17 at 4:25 pm with Nurse #3 revealed she was the nurse for Resident #7. She stated she was an agency nurse and this was the first time she had worked with the resident. Nurse #3 stated that she was not aware of Resident #7 being on contact isolation as she had not seen the resident yet on her shift. Nurse #3 reviewed Resident #7 ' s September 2017 medication administration record (MAR) and said it looked like she was on isolation because she had ESBL in her urine and that an order was written on 9/11/17 to start contact isolation.

An observation on 9/13/17 at 10:19 am of Resident #7 ' s room revealed the contact isolation sign remained on the door of her room. There was a cart with PPE outside of her room and a red barrel inside of her room.

An interview on 9/13/17 at 10:20 am with the Unit Manager for Resident #7 revealed the resident had a bacterial infection of her urine. She stated the infection was contained because she had a Foley catheter. The unit manager added that she had just returned to work after being off for a few days but if the physician had ordered contact isolation anyone entering the room should wear a gown and gloves.

An interview on 9/14/17 at 11:06 am with Nurse #4 revealed on 9/11/17 Resident #7 ' s primary physician was at the facility and reviewed the urinalysis results from 9/9/17. Nurse #4 added on the morning of 9/12/17 she started Resident #7 on contact precautions when she realized the physician had written the order but, other than placing the sign on the door the other required PPE hadn ' t been set-up yet.

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A review of September 2017 medication administration record (MAR) for Resident #7 identified an order for contact isolation for ESBL UTI until antibiotic is completed. This order was dated 9/11/17 at 4:36 pm. The first time the MAR was initialed for this order being completed was 9/12/17 at 7:00 pm.

An interview on 9/14/17 at 11:30 am with the DON revealed she was aware that Resident #7 had ESBL in her urine. She stated the weekend supervisor had contacted the on-call physician on 09/09/17 when she received the urinalysis results for Resident #7. The on-call physician provided a telephone order dated 09/09/17 for Nirtofuantoin Macro crystal 100 mg every 12 hours. The DON added that Resident #7 ' s primary physician reviewed the lab results on 9/11/17 and she changed the antibiotic to the Invanz because the resident was also being treated for pneumonia and the Invanz would cover both. She explained she was not sure why the on-call physician had not ordered contact isolation on 9/9/17 and that the primary physician ordered contact precautions on 9/11/17. The DON stated the facility would not implement contact isolation without a physician ' s order.

A phone interview on 9/14/17 at 12:22 pm with Nurse #5 revealed she was the weekend supervisor on 9/9/17 and had contacted the on-call physician regarding the results of Resident #7 ' s urinalysis. She added that the on-call physician ordered an antibiotic, but she didn ' t think she had ordered contact isolation. Nurse #5 stated she couldn ' t remember the name of the on-call physician she spoke with.

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A phone interview on 9/14/17 at 12:25 pm with the primary physician for Resident #7 revealed she had reviewed the urinalysis results on 9/11/17 and had started the resident on Invanz because it was a more appropriate antibiotic to treat both her ESBL UTI and her pneumonia. She stated she also started her on contact isolation on 9/11/17 because of the ESBL and the risk for contamination and spreading from contact with the resident ' s urine. The physician added that it was unfortunate that it took 2 days for the contact isolation to be started, but she had ordered it as soon as she reviewed the urinalysis results. She added that she had been in the facility most of the day on 9/11/17 and she could not recall what time she had ordered the contact precautions. The physician provided the name of the on-call physician that covered for her on 9/9/17.

A phone interview on 9/14/17 at 12:58 pm with the on-call physician revealed she had provided coverage for the facility on 9/9/17. She stated that contact isolation should have been started with a diagnosis of ESBL UTI. The on-call physician added that she could not recall if she had given them an order for contact isolation but assumed the facility would know that this was required with this type of infection.

An interview on 9/14/17 at 2:49 pm with the DON revealed it was her expectation that contact isolation precautions would be implemented in a timely manner and would include provision of PPE outside of the resident ' s room when ordered by the physician.