STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

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WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/12/18 through 02/17/18. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constituted substandard quality of care. An extended survey was conducted.	F 000		
F 641 SS=D	. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews the facility failed to accurately code a residents height on the minimum data set (MDS) for 1 of 1 residents sampled for nutrition that was a double amputee (Resident #121). The findings included: Resident #121 admitted to the facility on 01/30/18 with diagnoses that included acquired absence of right and left lower legs and others. Review of the most recent comprehensive minimum data set (MDS) dated 02/06/18	F 641	-Correction of specific deficiency and processes that may have led to the cited deficiency- Key members of the QAPI team met to determine the root cause of the citation related to F641. Further investigation revealed that the CDM, with guidance from the RD, used the resident's previous height, before amputation, and used a determined formula to calculate the resident's dietary needs. In the absence of a current height, the Certified Dietary Manager Coded 00 on the MDS assessment instead of – (dashes) as	3/2/18

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

Electronically Signed | 03/09/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1 revealed that Resident #121 was cognitively intact and required extensive assistance with activities of daily living. The MDS further indicated that Resident #121 weighted 153 pounds (lbs.) and had height recorded of 0 inches. The MDS had been completed by MDS Nurse #1. An observation of Resident #121 was made on 02/12/18 at 10:05 AM. Resident #121 was up in her wheelchair appropriately dressed for the weather. She was well groomed and was observed to have amputations of the right and left lower leg. An interview was conducted with MDS Nurse #1 on 02/17/18 at 10:22 AM. MDS Nurse #1 confirmed that she had completed the MDS assessment dated 02/06/18. MDS Nurse #1 further stated that she recalled questioning why there was no height available and she had reached out to the Dietary Manager (DM) to obtain an accurate height since Resident #121 had recently had an amputation. The MDS Nurse #1 stated she thought that the DM had obtained an accurate height and corrected the MDS. She stated that she would immediately modify and correct the assessment. An interview was conducted with the DM on 02/17/18 at 10:41 AM. The DM stated that she did not code a height on the MDS because it would alter her calculations for her body mass index (BMI) because Resident #121 was a double amputee. The DM stated she used Resident #121's height from a previous admission and subtracted 9% for each missing leg to calculate her needs and did not need an accurate height An interview was conducted with the Director of	F 641	instructed by the RAI manual. The determined root cause of the citation was that the CDM mistakenly entered incorrect values on the resident's assessment. The resident was not negatively affected related to the citation. An accurate height was obtained by the CDM and a corrected MDS assessment for resident # 121 was submitted on 2/20/18. -Procedure for implementing the plan of correction- The corrective measures implemented included that the Certified Dietary Manager reviewed the most current MDS assessments for all active residents, ensuring each resident had accurate documented weights and heights. Any noted inaccuracies were corrected and reported to the MDS coordinator and a corrected MDS was submitted. Completed 03/05/18. The Dietary Manager and MDS Nurse were educated on ensuring accuracy of assessments. Completed 2/20/18. -Monitoring procedure to ensure plan of correction is effective and facility remains in compliance- To ensure future compliance, as part of daily risk management, all new admission charts will be reviewed by members of the interdisciplinary team to ensure accurate heights and weights are recorded upon admission. Process change initiated on 2/19/2018 and will be ongoing as it represents a change in facility daily risk management protocol. The Administrator will oversee this process and submit findings to the QAPI team monthly. The QAPI team will	

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F 641	Continued From page 2 Nursing (DON) on 02/17/18 at 11:47 AM. The DON stated that she expected the staff to obtain a new height on each resident with each admission per the facility policy. She also stated she expected the staff to accurately code the MDS with the correct height that they obtained.	F 641	determine the effectiveness of the plan and recommend changes if necessary. This plan was submitted to the QAPI committee on 3/2/18. -Title of person responsible for implementing the plan of correction- CDM, MDS Coordinator (RN), LNHA -Date Corrective Action Completed 3/2/2018	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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 observations, record reviews, and staff interview the facility failed to clean and trim a dependent residents fingernails for 1 of 4 residents sampled for activities of daily living (Resident #122). The findings included: Resident #122 was admitted to the facility on 01/30/18 with diagnoses that included: heart failure, and acute verses chronic systolic congestive heart failure. Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/06/18 revealed that Resident #122 was cognitively impaired for daily decision making and required extensive assistance of 2 staff members with activities of daily living.	F 677	-Plan for correcting deficiency as well as processes that led to cited deficiency- The facility's process for providing ADL care for dependent residents, including nail care, provides that resident's nails are cleaned and trimmed during scheduled shower times in addition to daily visual checks and care provided as needed. A root cause analysis performed by members of the QAPI team determined that as noted in the surveyor's interviews with staff, they were aware of the facility's nail care policies and best practices. The root cause was determined to be that staff failed to adhere to these policies on this individual resident for three days during the recertification survey. Staff report this was due to oversight. Nail care was provided for resident #122 on 02/14/2018. -Procedure for implementing Plan of	3/2/18

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F 677	Continued From page 3 An observation of Resident #122 was made on 02/12/18 at 8:05 AM. Resident #122 was up in his wheelchair in the dining room with his breakfast tray in front of him. All 10 of his fingernails were approximately a quarter inch long and were noted to have dried brown substance under them. An observation of Resident #122 was made on 02/12/18 at 2:13 PM. Resident #122 was resting in bed with the head of bed elevated. All 10 of his fingernails were approximately a quarter inch long and were noted to have dried brown substance under them. An observation of Resident #122 was made on 02/13/18 at 9:40 AM. Resident #122 was up in his wheel chair at bedside. All 10 of his fingernails were approximately a quarter inch long and were noted to have dried brown substance under them. An observation of Resident #122 was made on 02/14/18 at 4:16 PM. Resident #122 was resting in bed with head of bed elevated. All 10 of his fingernails were approximately a quarter inch long and were noted to have dried brown substance under them. An interview was conducted with Nursing Assistant (NA) #2 on 02/14/18 at 4:16 PM. NA #2 confirmed that she was taking care of Resident #122 and she had just come on shift. She stated that fingernails were to be checked during showers and anytime that care was being provided. NA #2 stated that if she observed someone that needed their nails trimmed she would ask the nurse if the resident was a diabetic and if not then she would trim them but if they were diabetic than the nurse would trim them. NA #2 observed Resident #122's nails and agreed	F 677	Correction- Members of the Nursing Administrative team performed a visual check of all current residents to ensure proper ADL assistance had been provided, including nail care. No other issues were noted at the time of the inspection. Completed 02/15/2018 during recertification survey. Education was provided to all direct care staff regarding the facility's policies and procedures regarding ADL care. Completed 02/15/2018 -Monitoring procedure to ensure plan of correction is effective and facility remains in compliance- To ensure ongoing compliance the Director of Nursing will oversee a nail care monitoring program in which each resident's nails will be inspected by a member of the nursing administration team. These inspections will be performed on each resident once weekly for four weeks and two times monthly for an additional four months with any concerns addressed immediately. Initiated 2/15/2018 and ongoing. The Director of Nursing will report the Plan of Correction and findings to the Quality Assurance Committee no less than monthly for the duration of the initial plan. If substantial compliance is maintained the QAPI Committee will make recommendations for continued monitoring. This initial plan was submitted to and approved by the QAPI Committee on 03/02/18. Title of person responsible for implementing Plan of Correction Director of Nursing	

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F 677	Continued From page 4	F 677	Dates when corrective action was completed 03/02/2018	

they needed to be trimmed and cleaned. She stated that she would ask the nurse if he was a diabetic and if not she would take care of trimming them and cleaning them. She stated that she had just came on shift and had noticed the nails that needed to be cleaned and trimmed but had not had time to speak to the nurse yet.

An interview was conducted with NA #1 on 02/16/18 at 3:31 PM. NA #1 confirmed that she routinely cared for Resident #122 and had taken care of him on 02/12/18, 02/13/18, 02/14/18, and 02/16/18. She stated that Resident #122 was dependent on staff for all aspects of activities of daily living including nail care. NA #1 stated that she checked nails whenever she was providing care and she had "not paid much attention to his nails this week" because he had a lot of visitors and she was rushed to finish care. NA #1 stated that if she would have noticed them she would have cleaned them and trimmed them as long as he was not a diabetic.

An interview was conducted with the Nurse #1 on 02/16/18 at 4:15 PM. Nurse #1 stated that the NAs provided nail care to the residents unless the resident was a diabetic. If the resident was a diabetic the NAs would report that to the nurse and the nurse would trim them. Nurse #1 stated that the residents on his unit were alert and oriented and could ask for their nails to be trimmed except Resident #122 and he would expect the NAs to clean and trim his nails any time they needed it.

An interview was conducted with the Resident Care Coordinator on 02/16/18 at 3:54 PM. The Resident Care Coordinator stated that the NAs were responsible for cleaning and trimming nails

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F 677	Continued From page 5 as long as the resident was not a diabetic. If the resident was a diabetic then the nurses would have to trim the nails. The Resident Care Coordinator stated that she would expect nails to be trimmed at any time the staff noticed that they were in need of cleaning or trimming but especially while the staff was providing care to the resident. An interview was conducted with the Director of Nursing (DON) on 02/17/18 at 11:21 AM. The DON stated that she expected fingernails to be cleaned and trimmed any time they were long or dirty.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure the lift gate was in the elevated position before unloading a resident from the back of the facility van for 1 of 3 residents sampled for accidents (Resident #91). Resident #91 was pushed from the van out the back door and fell to the ground resulting in minimally displaced left sided rib fractures 4th through 9th, left base atelectasis (lung collapse) thought to be related to splintering secondary to rib fractures (where the bone splintered and	F 689	Past noncompliance: no plan of correction required.	3/9/18

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F 689	Continued From page 6	F 689		

punctured the lung), transverse fracture of the left femur, and scalp hematoma related to trauma with moderate laceration.

The findings included:

Resident #91 was initially admitted to the facility on 09/04/16 and was readmitted to the facility on 04/25/17 with diagnoses that included end stage renal disease, minimally displaced left sided rib fractures 4th through 9th, left base atelectasis thought to be related to splintering secondary to rib fractures, transverse fracture of the left femur, scalp hematoma related to trauma with moderate laceration, diabetes mellitus, and acquired absence of left lower leg.

Review of a facility document titled "Driver Safety and Training Competency Checklist" for Transportation Aide (TA) #1 dated 04/04/17 was made. The checklist indicated that TA #1 had received training in the following areas: using the facility vehicle, safe driving practices, prohibiting use of cell phone while driving, refueling protocol, properly securing wheelchairs in the vehicle, securing residents using seatbelts, and emergency situations. The form was signed by TA #1 and the Project Manager (PM). TA #1's individual competency check off list on using the facility's transportation van was included in the packet of training material. The competency check off list included all aspects of the van including use of the lift and loading/unloading residents. The competency check off list revealed that TA #1 had met all competencies on 04/04/17 and had been signed off by the PM.

Review of an incident report dated 04/21/17 at 9:30 AM read in part, received a call from TA #1

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F 689	Continued From page 7	F 689		

from the local dialysis clinic stating that Resident #91 had fallen from the facility's transportation van. TA #1 stated, "the resident is stating that she is ok and that just the back of her head hurts a little bit, no open areas noted, no bleeding, but the back of her head is noted to be having some swelling, she denies pain to her hips, legs, arms, back, buttocks, feet, and hands. I have called Emergency Medical Service (EMS) to transport her to the Emergency Room (ER)." Family was notified of the fall and that Resident #91 was being taken to the ER for evaluation. The report was signed by the Director of Nursing (DON).

Review of a statement signed by TA #1 dated 04/21/17 read in part, "while pushing another resident into the dialysis clinic her lunch cooler got caught on the wheel of the wheelchair and it pinched my left middle finger." TA #1 returned to the van and entered from the right side of the van, unhooked Resident #91's wheelchair and pushed her to the back of the van not realizing the lift gate was not up in place. The lift gate remained on the ground. Resident #91 fell backwards out of the van. TA #1 immediately spoke to Resident #91 and asked if she was alright and she stated she was alright. EMS was then notified as was the facility.

Review of the most recent quarterly Minimum Data Set (MDS) dated 01/23/18 revealed that Resident #91 was cognitively intact and required total assistance of 2 staff members. The MDS further revealed that Resident #91 required dialysis during the assessment period.

An interview was conducted with Resident #91 and her family member on 02/15/18 at 12:25 PM. The family member stated that Resident #91 had

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F 689	Continued From page 8	F 689		

fallen from the facility van in April of 2017 when the driver forgot to put the lift gate back up after unloading one resident and before attempting to unload Resident #91. Resident #91 stated that the driver "pushed me right off the back of the van" and I hit the ground "did not even see it coming." The family member stated that Resident #91 suffered broken ribs, hematoma to her head and other injuries and went to the hospital for a few days before returning to the facility. Resident #91 stated that she had recovered from her injures and had no further incidents with the van since the incident on 04/21/17.

An interview was conducted with TA #1 on 02/15/18 at 4:32 PM. TA #1 stated that she was also a Nursing Assistant (NA) who had worked at the facility for 3 years and had been driving the facility van for approximately 6 weeks but currently was no longer employed by the facility. TA #1 stated that she had received most of her training from TA #2 which "was minimal." TA #1 stated that she was shown how to use the lift, seat belts, and where the fire extinguisher was and she drove around and observed TA #2 for a couple of days and then she was released to transport residents independently. Prior to being released to transport residents independently TA #1 stated that the PM went over the procedures for using the lift and seat belt and did go on a test drive with her. TA #1 could not recall if she had completed a skills check off list at that time. TA #1 stated that she felt comfortable with her ability to transport residents when she was released to transport independently. TA #1 explained that the day of the incident 04/21/17 she had transported 2 residents to the local dialysis clinic and she had taken the first resident off the van and was carrying a cooler and the cooler got caught on the

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F 689	Continued From page 9	F 689		

wheel of the wheelchair and it jerked her fingers and she was in pain and crying and she thought she had broken her finger. TA #1 further stated that she was in a hurry and moving swiftly because she was late and she immediately returned to the van and went in the right side door and unbuckled Resident #91 and pushed her off the back of the van not realizing the lift gate was on the ground. TA #1 stated that she was in a hurry and did not hear or see the alarms in the van that would indicate that the lift was down. She added that Resident #91 had fallen out of the back of the van and landed on her back and hit her head, she then rolled to her left side and a bystander who she did not know pulled the wheelchair out from under her. She added that the dialysis clinic was surrounded by a lot of doctor's offices and there were nurses that came out and tried to assist. Resident #91 was complaining of her head and hip hurting but could not recall which hip. She stated that she felt the back of Resident #91's head and there was a knot but no bleeding that she could see. TA #1 stated that she called EMS and notified the facility of the incident and she stayed with Resident #91 until the medics arrived and transported her to the hospital. TA #1 stated that following the incident the facility offered retraining to drive the van but she declined the offer.

An interview was conducted with the DON on 02/15/18 at 03:25 PM. The DON stated that on 04/21/17 she received a call from TA #1, who was transporting Resident #91 that day to her dialysis appointment. TA #1 stated she had pushed Resident #91 off the back of the van with the lift gate in the down position (the lift gate was on the ground). The DON stated she immediately drove over to the dialysis clinic and Resident #91 was

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F 689	Continued From page 10	F 689		

already on the EMS stretcher. Resident #91 was alert and awake and was taken to the hospital for evaluation. The DON stated that at the time you could tell the resident hit the back of her head, she had a hematoma that was bleeding. The hospital discovered that Resident #91 suffered rib fractures and fractured hip as a result of the fall but no surgery was required. TA #1 told the DON that just before the incident, she unloaded another resident from the van and pushed that resident into dialysis holding the resident's lunch box. TA #1 stated that while pushing the other resident the lunch box got caught in the wheel of the wheel chair and it jerked TA #1's finger. TA #1 thought her finger was broken and she was in pain and crying. TA #1 stated she went in the right side door of the van and did not realize that she had left the lift gate in the down position. The DON explained that the van had a pressure sensitive alarm on the van's floor and if the gate was down and pressure was applied there was an audible and visual alarm that sounded. TA #1 stated that she was so frazzled she did not hear the alarm. The DON stated that Resident #91 remained in the wheelchair and no one moved her until EMS arrived.

An observation of the facility's transportation van was made on 02/15/18 at 3:50 PM. The van was a conversion (van converted to transport residents) van with a lift. The floor of the van was approximately 26 inches from the ground. There was hand control that was used to raise and lower the lift. There was a pressure sensitive sensor on the floor of the van that set off an audible alarm and a red flashing light inside the back of the van if the lift was in the down position. When the back doors of the van were open there was a visual sign located on the rear door that

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	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 689	Continued From page 11	F 689		

read "STOP!! Check lift position before moving resident toward exit door."

An interview was conducted with the PM on 02/15/18 at 3:55 PM. The PM described the procedure for unloading and loading 2 residents. The PM stated that after unloading the first resident in a safe location the lift gate was returned to the upright position and the driver entered the vehicle from the right side door and placed the 2nd resident on the lift gate and then lowered the lift gate and removed the 2nd resident. He added that he was responsible for training of new drivers and that most of his training scenarios were based on only one resident being transport.

An interview with the Executive Director (ED) was conducted on 02/15/18 at 4:00 PM. The ED stated that they had not thought about an accident happening with 2 residents being transported on the van until the accident happened.

An interview was conducted with TA #2 on 02/16/18 at 9:11 AM. TA #2 stated that he had worked at the facility for 5 years and had been driving the transportation van for 2 years. He added that he had received his training from the PM which included how to properly load/unload residents in the van. He added that the PM drove around and demonstrated how the process was completed, went over the security measures inside the van, the pressure sensitive plate on the floor of the van and the audible and visual alarm that went off if the lift gate was down and pressure was applied. TA #2 stated that the PM had verified his skills a few times in the parking lot by using a wheelchair with no resident and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 689	Continued From page 12	F 689		

they would go through the motions of proper loading/unloading the wheelchair. TA #2 stated that he did assist in training new drivers once the PM had done the initial training he would again go over the steps for loading/unloading and the safety features that were used. He added that he always trained the new drivers that once the first resident was off of the van and in a safe location you were to raise the lift back up and there was never a time that the lift should be left in the down position. TA #2 confirmed that he had done the same training steps with TA #1 and she had rode with him for about a week, first just observing then assisting and by the end of the week TA #1 was doing the steps and transports independently while he observed. TA #2 stated that once TA #1 had completed the training with him the PM would do a final check off and TA #1 was then released to transport residents independently. He added that TA #1 was doing very well with the transports and he had no concerns when she was released to drive and transport residents independently. TA #2 stated that on 04/21/17 the day of the incident with Resident #91 he was on an out of town appointment. When he returned to the facility, the Administrator and the PM went over the process for loading and unloading residents again and the new policy that stated we would only transport one resident at a time. After going over the training with the Administrator and the PM, TA #2 returned to the dialysis clinic to pick up the resident while Resident #91 was at the hospital. TA #2 stated that he had been trained that if there was an incident or an emergency he was to pull over and call for assistance and this included if the driver became injured.

An observation of TA #2 unloading Resident #91 at the local dialysis clinic was made on 02/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

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F 689	Continued From page 13	F 689		

at 10:10 AM. TA #2 was observed to back the facility's van to the door of the dialysis clinic and open the back doors of the van. When the back doors of the van were opened there was a visual sign located on the rear door that read "STOP!! Check lift position before moving resident toward exit door." Using the hand held control TA #2 lowered the lift gate from the back of the van to the ground and then raised to the loading position. TA #2 was observed to enter the van through the right side door and release the safety belts from Resident #91 and her wheelchair and push her backwards to the lift gate. Once on the lift gate TA #2 locked Resident #91's wheelchair wheels and exited the van and again using the hand held control lowered Resident #91 safely to the ground where she was removed from the lift gate and moved away from the vehicle. Before assisting Resident #91 into the dialysis clinic TA #2 lifted the gate using the hand held control and shut the rear doors of the transportation van and assisted Resident #91 into the dialysis clinic.

A follow up interview with the PM was conducted on 02/16/18 at 11:36 AM. The PM confirmed that he was responsible for training drivers of the facility's transportation van and had done so for 7-8 years. The PM stated that once an employee was assigned to drive the van he would sit down with the employee and complete a packet of paperwork and go through the training material on safety of the van, road safety, signage, proper speed limit, cell phone policy and emergency situations. The PM stated that he discussed emergency situations that included weather related issues, accident issues, and injury (both to driver and resident). He added that he always instructed the drivers that if they become injured for whatever reason they were to make sure the

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	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 14	F 689		

residents were safe and call both the facility and EMS if they were in need of medical assistance. The PM stated that if TA #1 had become injured on 04/21/17 then she should have stopped what she as doing and called the facility and requested assistance and if needed called EMS for medical assistance and he could not speak to why TA #1 did not call the facility and ask for assistance.

An interview was conducted with the Administrator on 02/16/18 at 12:00 PM. The Administrator stated that he believed TA #1 became so wrapped up in getting Resident #91 to her dialysis appointment that she did not follow what she had been trained to do and did not hear the alarm or see the flashing light. He added that he would have expected that if TA #1 was injured that she would have called the facility and requested assistance before attempting to unload Resident #91. The Administrator added that following the van incident on 04/21/17 the DON had driven the van back to the facility and the van was inspected by the PM and the Administrator and all safety features were in working order.

An interview was conducted with the Medical Director (MD) on 02/17/18 at 12:12 PM. The MD stated that she was new to the facility and had only been in the facility for about 30 days. The MD stated that she was notified of the incident with Resident #91 that occurred on 04/21/17 in the last 2 weeks. She stated that she had reviewed the plan of correction and the procedural/process changes and agreed with them. She stated that the audits were also reviewed and revealed that the plan of correction that was immediately put into place was effective. She added that the facility took swift and appropriate actions and there have been no other

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	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

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F 689	Continued From page 15	F 689		

incidents like this with the van since the 04/21/17 incident with Resident #91.

The facility provided a plan of correction with a correction date of 04/26/17. The plan of correction included:

F689:

- On 04/21/17 TA #1 transported 2 residents to the local dialysis clinic and proceed to unload the first resident and accompany the resident into the clinic. While assisting the resident into the clinic the cooler that TA #1 was carrying became entangled in the wheelchair pinching her finger. TA #1 returned to the van and entered through the right side door and pushed Resident #91 out of the back of the van not realizing she had left the lift gait lowered to the ground. Resident #91 fell backward out of the van to the ground, TA #1 immediately exited the van and checked on Resident #91 and called EMS and the facility. Resident #91 was transported to the local ER for evaluation and treatment.
- All transportations were immediately suspended and the van was returned to the facility.
- Upon return to the facility the van was immediately inspected by both the Administrator and the PM and all aspects of the van including safety alarms were in correct working order.
- The policy and procedure for loading and unloading was changed to include the provision that the lift gate was never to be left in the down position.
- The facility would only transport 1 resident at a time.
- Visual reminders were added to both of the facility's transportation vans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 16 - All TAs were reeducated on the policy/procedure changes with observed return demonstration before being allowed to transport residents. - The plan of correction was submitted to the medical director for review and the Administrative personnel would observe loading/unloading of residents at the facility 4 times a week for 4 weeks then at random intervals. - Findings of the audits reported to the Quality Assurance Performance Improvement (QAPI) monthly. - The plan of correction was completed on 04/26/17 when the DON observed the safe loading/unloading of Resident #91 at the dialysis clinic after her return to the facility from the hospital. The plan of correction was validated on 02/16/18 and 02/17/18. The validation included: -observation of TA #2 loading/unloading Resident #91 at the facility and at the dialysis clinic. -Interviews with the TA #2, TA #3, and TA #4 verifying the policy/procedural changes that went into effect 04/21/17. -Review of the policy/procedural changes that occurred effective 04/21/17. -Review of the monitoring that occurred weekly x 4 as stated in the plan of correction. Additional monitoring was also evident through 08/2017.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		3/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 695	Continued From page 17 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family and staff interviews the facility failed to administer oxygen at 2 liters per minutes as prescribed by the physician to 1 of 2 residents sampled for respiratory care (Resident #122). The findings included: Resident #122 was admitted to the facility on 01/30/18 with diagnoses that included: heart failure, acute verses chronic systolic congestive heart failure. Review of a physician order dated 01/30/18 read in part, oxygen at 2 liters per minute via nasal cannula (NC). Review of the electronic Treatment Administration Record (eTAR) dated 02/01/18 through 02/28/18 read in part, oxygen at 2 liters per minute via NC. The times listed were 6:00 AM, 2:00 PM, and 10:00 PM and all times were electronically signed by the staff indicating that Resident #122 was receiving 2 liters of oxygen via NC at those times. Review of the electronic Medication Administration Record (eMAR) dated 02/01/18 through 02/28/18 revealed that Resident #122's oxygen level was above 90% (90-100% was normal) with each check that was performed. Review of the most recent comprehensive	F 695	-Plan for correcting the specific deficiency and processes that led to cited deficiency- Key members of the QAPI committee met to determine the root cause of the citation related to F695 and determine a plan of correction. As a result of the investigation and staff interviews two root causes to the deficient practice were identified. The first root cause identified that staff were not conscientious of monitoring all aspects of resident #122's oxygen therapy. It was identified that while staff were checking for the presence of the nasal canula, they did not consistently monitor the prescribed flow. The second root cause identified was that staff did not effectively communicate any changes or discrepancies to the assigned nurse. -Procedure for implementing an acceptable plan of correction- Resident #122's oxygen settings were corrected on 02/17/18. The Director of Nursing and other members of the administrative nursing team performed an audit to ensure that other residents in the facility were receiving oxygen in compliance with their prescribed orders. No other discrepancies were noted. Completed 02/19/18. The Director of Nursing provided staff education regarding oxygen administration monitoring and accurate documentation.	

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F 695	Continued From page 18 minimum data set (MDS) dated 02/06/18 revealed that Resident #122 was cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further indicated Resident #122 required oxygen during the reference period. An observation of Resident #122 was made on 02/12/18 at 8:05 AM. Resident #122 was up in his wheel chair in the dining room with his breakfast tray in front of him. He was noted to have a nasal cannula in his nose delivering oxygen via a portable oxygen tank secured in a cart. The regulator on the portable oxygen tank indicated that Resident #122 was receiving 4 liters of oxygen per minute. Resident #122 was in no distress. An observation of Resident #122 was made on 02/12/18 at 2:13 PM. Resident #122 was resting in bed with the head of bed elevated. He was observed to have a nasal cannula in his nose delivering oxygen via a bedside oxygen concentrator. The concentrator indicated that Resident #122 was receiving 4 liters of oxygen per minute. Resident #122 was in no distress. An observation of Resident #122 was made on 02/13/18 at 9:40 AM. Resident #122 was up in his wheel chair at bedside. He was observed to have a nasal cannula in his nose delivering oxygen via a bedside oxygen concentrator. The concentrator indicated that Resident #122 was receiving 4 liters of oxygen per minute. Resident #122 was in no distress. An observation of Resident #122 was made on 02/14/18 at 4:16 PM. Resident #122 was resting in bed with head of bed elevated. He was	F 695	Completed 02/27/18. The Therapy Director educated therapy staff on communication with nursing staff in regards to noted oxygen discrepancies. Completed 03/05/18 -Monitoring procedure to ensure the plan of correction is effective and that deficiency remains in compliance with regulatory requirements- To ensure ongoing compliance the Director of Nursing will oversee an audit program recommended by key members of the QAPI team. The DON or designee will audit oxygen administration devices to ensure settings are correct versus corresponding MD orders. Any discrepancies will be addressed immediately. These audits will be performed on all applicable residents weekly for four weeks, then two times monthly for four months. Initiated on 2/19/2018 and ongoing The Director of Nursing will report the findings of this plan of correction to the QAPI team monthly for the duration of the timeline provided. The Committee will recommend changes as deemed necessary. This initial plan was submitted to and approved by the QAPI Committee on 03/02/18. -Person responsible for implementing the acceptable plan of correction Director of Nursing -Dates when corrective action will be completed 03/05/18	

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F 695	Continued From page 19	F 695		

observed to have a nasal cannula in his nose delivering oxygen via a bedside oxygen concentrator. The concentrator indicated that Resident #122 was receiving oxygen at 4 liters per minute. Resident #122 was in no distress.

An observation of Resident #122 was made on 02/15/18 at 11:27 AM. Resident #122 was resting in bed with head of bed elevated. He was observed to have a nasal cannula in his nose delivering oxygen via a bedside oxygen concentrator. The concentrator indicated that Resident #122 was receiving oxygen at 4 liters per minute. Resident #122 was in no distress.

An interview was conducted with Nursing Assistant (NA) #1 on 02/16/18 at 3:31 PM. NA #1 confirmed that she routinely cared for Resident #122 and had cared for him on 02/12/18, 02/13/18, 02/14/18, and 02/16/18. She stated she had to provide assistance to him for all aspects of activities of daily living. NA #1 added that Resident #122 wore oxygen at all times and was supposed to be receiving 2 liters per minute via NC. She stated that while she was in the room with Resident #122 she would generally check and make sure his oxygen was in his nose and that he was receiving 2 liters per minute. NA #1 added that if the oxygen flow rate was different than 2 liters per minute she would communicate that with the nurse. NA #1 stated that she had not noticed that Resident #122 was on 4 liters of oxygen throughout the week while she was caring for him. She added that she routinely obtained vital signs on Resident #122 and that included a pulse oximeter and his level was always above 90%.

An observation of Resident #122 was made on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

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WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 695	Continued From page 20	F 695		

02/16/18 at 4:15 PM. Resident #122 was resting in bed with head of bed elevated. He was observed to have a nasal cannula in his nose delivering oxygen via a bedside oxygen concentrator. The concentrator indicated that Resident #122 was receiving oxygen at 3 liters per minute. Resident #122 was in no distress. Resident #122's family was at bedside and indicated that the Physical Therapist (PT) had turned Resident #122's oxygen down to 3 liters per minute during his therapy session. The family member stated that Resident #122 was on no oxygen at home and this week he had been on 4 liters per minute. The family member added she did not know why the oxygen was at 4 liters per minute but added she was hopeful that Resident #122 would not need the oxygen much longer.

An interview was conducted with Nurse #1 on 02/16/18 at 4:18 PM. Nurse #1 confirmed that he routinely cared for Resident #122 and had cared for him on 02/13/18 and 02/16/18. He also confirmed the order for Resident #122 that indicated he required oxygen at 2 liters per minute via NC. Nurse #1 also confirmed that Resident #122 was currently receiving 3 liters per minute of oxygen via NC. Nurse #1 stated that he generally checked the flow rate of oxygen 2 times a day and had not noticed that the flow rate was higher than 2 liters per minute. He added that he would expect who ever turned the oxygen up or down to report that to him so that he could communicate that with the medical doctor (MD). Nurse #1 stated that each shift they checked Resident #122's oxygen saturation levels and Resident #122 was always above 90%.

An interview was conducted with the PT on 02/16/18 at 4:23 PM. The PT confirmed that she

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	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

(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 695	Continued From page 21 had worked with Resident #122 on 02/16/18 and she had turned his oxygen from 4 liters per minute to 3 liters per minute. The PT stated that the family member present during the therapy session had stated that Resident #122 had not been on oxygen at home and he was not aware that he had been on 4 liters per minute at the facility. The PT indicated that at that point she had turned Resident #122's oxygen down to 3 liters and she forgot to report it to Nurse #1. The PT stated that she should have communicated with Nurse #1 but she had simply just forgot. An interview was conducted with the Resident Care Coordinator for Rehab on 02/17/18 at 11:21 AM. She stated that the nurses were expected to check the regulators for residents that were on oxygen to ensure that they were on the correct amount. The Resident Care Coordinator for Rehab stated that residents that received oxygen were required to have a daily pulse oximeter to check their oxygen levels and at that point the nurses should be checking the concentrators. She stated she would have expected for Resident #122 to be on 2 liters of oxygen per minute as ordered and any changes made to the amount of oxygen to be communicated to the nurse and MD. An interview was conducted with the Director of Nursing (DON) on 02/17/18 at 11:30 AM. The DON stated she expected that Resident #122 would be on 2 liters of oxygen via NC per order and she expected the nurses to check the flow of oxygen throughout the day to ensure the correct dose was being delivered to the resident.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

(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 761	Continued From page 22 §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to remove expired medications from 1 of 2 medication carts. The findings included: An observation of the 300 hall medication cart on 02/17/18 at 12:19 PM revealed there was an open bottle of Calcium with Vitamin D tablets with approximately 50-60 tablets left in the bottle with an expiration date of 11/2017 in the cart available	F 761	-Plan for correcting specific deficiency and process that lead to deficiency cited- The expired medications identified were removed from the medication cart on 02/17/18. Key members of the QAPI team met to review the facility's protocols for monitoring medication storage. While it is the facility's expectation that every nurse is responsible for the cleaning, organizing and monitoring medication carts for expired medications during their	

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F 761	Continued From page 23 for use. In addition, there was an open bottle of Mucinex 600 mg 12 hour extended release tablets with approximately 200 tablets left in the bottle with an expiration date of 09/2017 in the cart available for use. An interview with the LTC Unit Manager on 02/17/18 at 12:19 PM revealed their process was to check the medication carts on a weekly basis and remove any outdated medications and send them to the pharmacy to be discarded. The Unit Manager stated the Calcium with Vitamin D and the Mucinex should have been removed from the cart and sent back to the pharmacy to be discarded. The Unit Manager went on to say checking the carts weekly for out of date medications was one of her responsibilities and was the responsibility of the nurse on the cart to also check the expiration date as they were dispensing medications to the residents. The Unit Manager stated that she and the nurses missed the outdated medications on the cart and she was not sure if any of the residents had received the out of date medications. An interview was conducted with the Director of Nursing (DON) on 02/17/18 at 12:55 PM. The DON stated she expected the nurses and Unit Managers to go through the medication carts and the Medication room weekly and remove any expired medications and return them to the pharmacy for destruction.	F 761	shift on a daily basis, third shift nurses were historically responsible for a complete inspection of medication carts nightly. The root cause analysis for the cited deficient practice determined that there was no standardized process and oversight for this action. -Procedure for implementing acceptable plan of correction- The QAPI team's proposed corrective action and improvement plan included education to all nursing staff on the facility's procedures and expectations for inspecting medication storage areas. Completed 02/27/18. The Director of Nursing developed a checklist/monitoring tool that is to be completed nightly by designated third shift nurses. This tool will be submitted to and reviewed by the DON daily. Any issues or concerns identified will be addressed timely. All medication storage areas were assessed for expired and/or inappropriately stored medications on 2/17/18 with no other discrepancies noted. -Monitoring procedure to ensure the plan of correction is effective and that specific deficiency cited remains in regulatory compliance- To ensure continued compliance and effectiveness of the initiated changes, the DON or designee will inspect all medication storage areas, including medication carts, once weekly for four weeks and twice monthly for four months. If substantial compliance is maintained the current plan will be added to the facility's ongoing QA program. The DON will report findings of this plan	

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	345401	A. BUILDING _____ B. WING _____	C 02/17/2018

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F 761	Continued From page 24	F 761	monthly to the QAPI committee. If needed, the committee will recommend changes as deemed necessary. This initial plan was submitted to and approved by the QAPI Committee on 03/02/18. Title of person responsible for implementing acceptable plan of correction Director of Nursing Date when corrective action completed 03/02/18	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		3/8/18

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F 842	Continued From page 25	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 26 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility staff failed to accurately document an incident that had occurred in a resident's medical record and failed to accurately record the non-use of prescribed protective foot coverings in 2 of 2 sampled residents (Residents #35 and #78). The findings included: 1. Resident #35 was admitted to the facility with diagnoses that included: sepsis, urinary tract infection, type II diabetes, hemiplegia and generalized anxiety disorder among others. A review of Resident #35's most recent comprehensive assessment (MDS) dated 11/24/17 indicated moderate impairment in cognition with no noted behaviors or psychosis. The resident required extensive assistance with most activities of daily living while being totally dependent upon staff for completion of bathing and transferring. A review of a nurse's note dated 11/18/17 at 6:09 PM documented by Nurse #2 stated in part "No complaints of pain or discomfort from previous fall. Will monitor for any problems." Further review of nurses revealed no note prior to Nurse #2's with any mention of a fall or incident regarding resident. Follow up notes dated 11/19 through 11/22 were entered into the electronic record all stating resident had suffered a fall on 1/17/17. A nurse's note entered on 11/20 at 12:54 AM stated: "No apparent difficulties noted from recent fall on 11/17/17." - Nurse #3	F 842	-Plan for correcting specific deficiency and processes that lead to deficiency cited Two incidents were cited under F842 related to inaccurate medical record documentation. Key members of the QAPI team met to determine the root cause of the citation. Initial investigation revealed that resident #35 sustained a minor foot injury due to an incident unrelated to a fall which was later documented as occurring status post fall. Additionally, one resident record contained documentation that PODUS boots were present on resident prior to the facility having received the boots. Two potential root causes were identified for these documentation errors. The first root cause was that nurses were not always assuring that they verify presence of equipment placed on Medication Administration Record and type of incident contributing to injury. The second root cause was that order entry nurse was not assuring presence of equipment in facility prior to placing order on Medication Administration Record. An Addendum note was added to Resident #35's EMR to clarify the noted discrepancy of foot injury resulting from a "mash" instead of a fall. This occurred on 3/08/18. The Medication Administration Record for Resident #78 was corrected via late entry to indicate PODUS boots were not present until 2/14/18. Completed 3/8/2018	

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F 842	Continued From page 27 A review of the facility provided fall/incident logs on 2/14/18 at 3:43 PM revealed Resident #35 had no logged fall dated 11/17/17 as indicated in his electronic record per nurse's notes. An interview occurred with Nurse #2 on 2/14/18 at 2:44 PM in which she reported she could not remember if resident had a fall or not and could not explain why she had documented resident had a fall on or around 11/17/17. She reported she "must have been told" there had been an incident/fall at the beginning of her shift. During an interview with Nurse #3 on 2/15/18 at 7:30 AM it was reported she could not recall why she wrote in her notes about a fall. She reported being unable to recall if there had been an incident regarding the resident's foot, a fall or if an incident had occurred at all. An interview on 2/14/18 at 3:24 PM with the Executive Director who revealed Resident #35 had not had a fall but had an incident where he injured his foot on 11/17/17. She could not answer why the incident was logged as a fall in the electronic record but the electronic record was "incorrect" and Resident #35 had not fallen on that date. An interview with the Director of Nursing on 2/16/18 at 11:00 AM revealed she expected documentation in resident's electronic record be correct. An interview with the Administrator on 2/17/18 at 11:14 AM revealed it was his expectation that all electronic documentation be correctly entered into their system.	F 842	-Procedure for implementing an acceptable plan of correction for this cited deficiency – Director of Nursing and designees completed a facility wide review of documentation related to incident reports for all incidents occurring in the previous 30 days to assure all current documentation is accurate. Incident reports from 01/12/2018-02/12/2018 were reviewed and all corresponding documentation was found to accurately identify the type of incident resulting in physical injury. Completed 03/8/18. Additionally, an audit of all resident records with prescribed assistive devices was performed to identify any Medication Administration Record discrepancy. No discrepancies noted. Completed 2/26/18. Facility wide education to all nurses completed on 2/27/18 regarding expectation and requirements of accurate documentation. -Monitoring procedure to ensure plan of correction is effective and cited deficiency remains within regulatory compliance- The Director of Nursing or designee will review all reported incidents to ensure accurate subsequent charting has occurred. This will occur five times a week for four weeks and twice monthly for four months. Initiated 2/13/2018 and ongoing. The Director of Nursing or designee will also review all Medication Administration Records for all residents with orders for assistive devices, including visual checks of equipment, to ensure accurate charting has occurred. This audit will occur twice weekly for four	

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F 842	Continued From page 28 2. Resident #78 was admitted to the facility with diagnoses that included: Osteolysis, urinary tract infection, weakness, type II diabetes, anemia and chronic pain among others. A review of Resident #78's most recent comprehensive assessment (MDS) dated 1/16/18 indicated Resident #78 to be cognitively intact with no noted behaviors or psychosis. The resident was coded as requiring extensive assistance with most activities of daily living (Resident #78 was coded as independent with eating). The assessment also indicated that Resident #78 had a stage one or greater pressure ulcer. A review of physician's orders on 2/12/18 at 10:58 AM revealed an order for "PODUS boots to both legs" Observation of Resident on 2/12/18 at 3:38 PM revealed resident to be up, in his recliner watching television with no pressure reducing boots on either of his feet. An additional observation of Resident #78 on 2/13/18 at 11:08 AM revealed resident to be in his recliner watching television with no pressure reducing boots on either of his feet. Observation of Resident #78 on 2/14/18 at 8:49 AM revealed resident to be out of bed watching television with no pressure reducing boots on either foot. An interview with Resident #78 on 2/15/18 at 11:08 AM revealed the first time he had seen or worn the boots was the previous day. He	F 842	weeks and twice monthly for four months. Initiated 2/19/2018 and ongoing. Any noted issues will be corrected immediately and reported to QAPI team. The Director of Nursing will report findings of both of the above audits to the QAPI team monthly for the duration of the timeline provided. The Committee will recommend changes as deemed necessary. The initial plan for all of the above was submitted and approved by the QAPI Committee on 03/02/18. -Person responsible for implementing the plan of correction- Director of Nursing Date when corrective action completed 03/08/2018	

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F 842	Continued From page 29	F 842		

reported up until that time he did not know he had to wear them and no one had informed him that he should be wearing the boots.

During an interview with Nurse #2 it was revealed that the pressure reducing boots had been ordered the previous week. She further reported resident had been wearing them since 2/12/18.

A review of Resident #78's electronic medication administration record revealed "POTUS BOOTS TO BOTH LEGS" order date: 2/07/18, start date: 2/07/18. Further review of the MAR revealed it being signed off on by nurses on all three shifts starting on 2/9/17.

During an interview with the Social Worker on 2/15/18 at 2:32 PM it was revealed the pressure reducing boots were ordered the previous Friday and delivered to the facility on 2/12/18.

An interview with the Director of Nursing on 2/16/18 at 11:00 AM revealed she expected documentation in resident's electronic record be correct and each residents electronic medication administration record be correct with treatments of medications not being signed off if it/they were not provided.

An interview with the Administrator on 2/17/18 at 11:14 AM revealed it was his expectation that all electronic documentation be correctly entered into their system.