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| AVANTE AT WILKESBORO | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and | F 584 | | 5/31/18 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/24/2018 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 584 | Continued From page 1<br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to repair a cracked indention in the floor (outside of room #104) and clean a yellowish/brownish smear on the wall of 1 room (Room 105) on 1 of 2 rehab halls.<br><br>Findings Included:<br><br>1. Observation of the floor outside of room #104 on the rehab hall on 04/30/18 at 4:27 PM revealed an oval shaped indention with depth and cracking around the center of the indention. The indention measured width (W)2.5 inches x length (L)3.25 inches x depth (D)5/16 of an inch.<br><br>Observation of the floor outside of room #104 on the rehab hall on 05/3/18 at 12:23 PM revealed an oval shaped indention with depth and cracking around the center of the indention. The indention measured width (W)2.5 inches x length (L)3.25 inches x depth (D)5/16 of an inch.<br><br>2. Observation of the wall at the foot of the resident's bed in room #105 on 04/30/18 at 4:30 PM revealed a smear consisting of a yellowish/brownish substance of an unknown origin.<br><br>An observation of the wall at the foot of the resident's bed in room #105 on 05/3/18 at 12:27 PM revealed a smear consisting of a yellowish/brownish substance of an unknown origin to continue to be visible on the wall.<br><br>An interview with the Maintenance Director on | F 584 | F 584 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The indention in the floor outside room #104 was repaired on 5/4/18. The indented tile was remove and a new tile was placed at the spot presenting a smooth even surface.<br>2. The smear of unknown substance in resident room #105 was cleaned off on 5/4/18.<br>3. The Administrator and Director of Maintenances conducted an audit of current facility residents rooms and facility common areas on 5/4/18, to identify indentations in the tile floor that could present a safety hazard for residents or staff. No other issues were identified.<br>4. The Administrator and Housekeeping Manager conducted an audit of resident rooms on 5/4/18 to identify marks on walls that need to be addressed. Cleaning/painting was completed when identified.<br><br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Administrator, Director of | |

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| F 584 | Continued From page 2<br>05/04/18 at 3:38 PM revealed he utilized a computer system to log and monitor maintenance requests in which he checked regularly throughout every day he was in the building. He reported he had no outstanding routine maintenance he had yet to repair. He further reported he attempted to address all maintenance requests within the building the same day they were reported. He stated he had a maintenance assistant who was responsible for monitoring the electronic reporting system and addressed the incoming maintenance requests.<br><br>An interview with the Housekeeping Director on 05/04/18 who reported he expected his staff to complete regular room cleaning daily and complete deep cleaning of rooms in correlation to the scheduled days. He further stated the facility had a wall cleaning schedule in which all room walls were washed and cleaned at least once per month. He reported he expected his staff to spot clean resident room walls whenever they were noted to need a wipe down.<br><br>During an environmental tour on 05/04/18 at 4:39 PM with the Housekeeping Director, Maintenance Director and Administrator the Housekeeping Director verified the yellowish/brownish smear that was still located on the wall in room #105 and had no explanation on why it had been missed and reported his staff should have noted the smear during the daily cleaning and removed it from the wall. Similarly, the Maintenance Director verified the cracked and chipped indention in the floor outside of room #104 and reported he had no explanation on why it had not been repaired. He reported he tried to see and replace all flooring chips, cracks and indentions when he saw them. | F 584 | Maintenance and Housekeeping manager provided in service education for the nursing staff, maintenance staff and housekeeping staff beginning on 5/8/18, regarding reporting needed repairs to proper employees to enable timely repair.<br>2. The Maintenance director provided in service education to facility staff beginning on 5/30/18, regarding reporting of broken or dented tiles utilizing the Point Click Care maintenance work order (TELS) reporting system. The in service education will be provided during orientation for newly hired staff.<br><br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Administrator, Director of Maintenance and Housekeeping manager will make weekly rounds together /for 4 weeks and then monthly for 3 months to identify and institute any repairs or additional cleaning needed according to facility protocol.<br>2. The Housekeeping manager will observe 20 rooms weekly for 4 weeks and 10 monthly for 3 months, to validate walls are cleaned properly.<br>3. The Administrator, Director of Maintenance and Housekeeping manager will analyze audits/reviews for patterns/trends and report in the Safety Committee and Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on | |

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| F 584 | Continued From page 3<br><br>During an interview with the Administrator on 05/04/18 at 5:08 PM he reported it was his expectation that maintenance and housekeeping issues be addressed and remedied promptly. | F 584 | outcomes/trends identified.<br><br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and staff interviews, the facility failed to protect a cognitively impaired resident (Resident #9) from physical abuse from another resident (Resident #132) for 1 of 2 sampled residents reviewed for abuse.<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on 10/01/16 with diagnoses which included a history | F 600 | F 600 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #132 no longer resides in the facility.<br>2. Resident #9 was interviewed by the Social Services Director on 5/29/18 to insure she felt safe in her residence and insure that there is no on-going trauma | 5/31/18 |

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| F 600 | Continued From page 4<br>of falling, vascular dementia, low vision in the right eye and blindness in the left eye, hypertension and others.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 02/08/18 revealed the resident had moderately impaired cognition for daily decision making and required limited assistance of 1 with bed mobility, transfers and walking with walker and required extensive assistance of 1 person with personal hygiene and bathing. The MDS also indicated Resident #9 had no behavioral symptoms during the assessment period.<br><br>A review of Resident #9's nurse's note dated 03/29/17 revealed Nurse #7 had been informed that Resident #9 was ambulating with her walker down the hallway when Resident #132 grabbed her arm and pulled her close to him and grabbed Resident #9 in her crotch area. Resident #9 was able to pull herself away from Resident #132 and continued to walk with her walker down the hallway. Resident #9 was assessed for injury and none was found, there was no acute distress noted, but emotional support was provided. Resident #9 continued to walk in the hallway with her walker but was directed away from Resident #132's room to prevent further issues. The note further indicated that the Director of Nursing (DON) was notified as well as the responsible parties for both Resident #9 and Resident #132.<br><br>Resident #132 was admitted to the facility on 12/04/15 and readmitted on 07/15/16 and was discharged on 06/21/17. Resident #132's admitting diagnoses included chronic obstructive pulmonary disease (COPD) with exacerbation, dysphagia, dementia without behaviors, diabetes | F 600 | from event of 3/29/17. Resident does not remember incident and feels safe and well cared for.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Administrator/The Director of Nursing initiated on 5/23/18 in service education for all staff in regards to the facilities Abuse, Neglect and Exploitations Policy. If or when any alleged abuse is observed by any staff, the staff will secure the alleged abuser from general resident population.<br>2. The in service education will be provided during orientation for newly hired staff.<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing will analyze audits/reviews reports of alleged allegations of Abuse, Neglect and Exploitation for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br>2. The administrator will monitor all Initial Allegation reports and Investigation Reports to identify and trends.<br><br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 600 | Continued From page 5 | F 600 | | |

and others.

The quarterly MDS dated 03/09/17 revealed Resident #132 was cognitively impaired for daily decision making and was independent with set up for most activities of daily living except personal hygiene which required the assistance of 1 person. No behaviors were exhibited.

On 03/30/17 the psychologist saw Resident #132 and reported back to the Administrator and DON although Resident #132 had some depression and short term memory deficits, he was aware of the consequences of his actions. Resident #132 adamantly denied the incident to the psychologist. On 03/30/17 Resident #132 was sent to the local hospital emergency room for evaluation of aggressive behaviors related to the incident the previous evening with Resident #9.

On 03/30/17 Resident #132 returned to the facility from the hospital. The physician at the hospital stated the resident was alert and oriented to person, place and time, and was aware of the consequences of bad behavior. Resident #132 was returned to the facility because he was not exhibiting behaviors while at the hospital. Resident #132 was placed back on one on one care during waking hours.

Nurse Aide (NA) #6's written statement dated 03/30/17 indicated that as she rounded the corner she saw Resident #132 sitting in his wheelchair in his doorway. She stated he looked up and down the hall but did not see her on the hallway. NA #6 stated he and Resident #9 were the only ones on the hall and as Resident #9 walked by on her walker, Resident #132 grabbed her arm and puller her down toward him in his wheelchair and

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then with his other hand groped her crotch above her clothing. NA #6 stated Resident #9 appeared distressed and NA #6 began moving toward them to intervene but Resident #9 was able to free herself from Resident # 132 before NA #6 got to them. NA #6 stated that once she determined all residents were safe she went and reported the incident to Nurse #7.

On 05/02/18 at 4:21 PM an interview with NA #6 revealed she had worked at the facility for over a year. She stated the evening of the incident she was turning the corner and coming up the hallway when she witnessed Resident #132 grab Resident #9 pull her down to him and with his other hand groped her crotch. NA #6 stated she made sure Resident #9 was safe and okay and then placed Resident #132 in his room still in his wheelchair and went and reported the incident to Nurse #7. She stated Resident #132 was alert and oriented but Resident #9 had dementia and was alert but not oriented. NA #6 stated she and Nurse #7 went into his room and talked with him about his inappropriate behavior toward Resident #9. NA #6 stated she and Nurse #7 kept a close watch of him until he went to bed that evening. NA #6 stated Resident #132 was then moved to another unit across from the nursing station under close observation.

On 05/01/18 at 11:10 AM an observation of Resident #9 revealed her lying in bed sleeping with her family member sitting at her bedside. A family interview was initiated and the family member stated the facility had called them and told them about an incident that had occurred last year in which she was walking in the hallway looking for her husband and another resident grabbed her arm. The family member stated

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Resident #9 was not hurt and had not said anything about the incident to the family.

On 05/03/18 at 3:38 PM a phone interview with Nurse #7 revealed she had worked at the facility for about a year but was no longer employed there. She stated she remembered the incident but stated she had not witnessed it but was reported to her by NA #6. Nurse #7 stated she took NA #6 into Resident #132's room after the incident to talk with him about what he had done and stated Resident #132 adamantly denied doing anything to Resident #9. Nurse #7 stated she further told Resident #132 he could not touch another resident and stated she requested him to remain in his room the rest of the night and he agreed to. Nurse #7 stated she had a NA to stay with him and monitor him the rest of the evening. Nurse #7 stated she went to check on Resident #9 and she told the nurse she had been grabbed by a man but did not want to say much about it because she did not want to get anyone in trouble. Nurse #7 stated Resident #9 did not appear to be too terribly upset about the incident. Nurse #7 stated she then called and reported the incident to the DON and called and informed the families of both residents what had happened.

On 05/04/18 at 3:58 PM an interview with Nurse #8 revealed she remembered the incident and stated Resident #9 was always looking for her husband who had been at the facility but had died. She stated Resident #9 had walked up to her after the incident and told her that she was scared and that she knew that was not her husband because he would never grab her like that man had grabbed her. Nurse #8 stated she walked Resident #9 back to her room and told her to stay away from Resident #132 the rest of

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| F 600 | Continued From page 8<br>the evening. Nurse #8 stated Resident #132 had gone into Resident #9's room several times and had to be re-directed out of her room. Nurse #8 stated Resident #132 had grabbed another resident (could not remember her name) but she was able to get away from him. Nurse #8 also stated Resident #132 had kissed another female resident (could not remember her name) and called her his girlfriend. Nurse #8 stated she considered the incident to be sexual abuse because Resident #132 had intimidated and frightened Resident #9 when he grabbed her and groped her crotch area. | F 600 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free | F 604 | | 5/31/18 |

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| F 604 | Continued From page 9<br>from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident, and staff interviews the facility failed to maintain an environment that was free from physical restraints for 1 of 2 residents (Resident #17) who were in a rock and go wheelchair which prevented the resident from getting up and restricted him from wheeling himself.<br><br>The findings included:<br><br>Resident #17 was admitted to the facility on 06/06/17 with diagnoses that included Parkinson's disease, repeated falls, and weakness.<br><br>Review of the most recent quarterly minimum data set (MDS) 03/01/18 revealed that Resident #17 was mildly cognitively impaired and required extensive assistance of 2 staff members with transfers and limited assistance of one staff member with ambulation in the corridor. The MDS indicated no restraints were used. Additional review of the medical record revealed no restraint assessment or diagnosis for the physical restraint.<br><br>Review of care plan revised on 04/06/18 read in part, Resident #17 was at risk for falls related to gait/balance problems and Parkinson's disease. | F 604 | F 604 Deficiency corrected<br><br>• The Plan for correcting the specific deficiency:<br>1. Resident #17 was evaluated by a Physical Therapist in regards to the Rock and Go Wheelchair being a restraint. The Physical Therapist evaluated Resident #17 ability to stand from multiple surfaces including a regular wheelchair, straight back chair and his bed on 5/8/18. Resident #17 was unable to independently stand from any surface, therefore the Rock and Go Wheelchair is not a restraint in regards to Resident #17 in comparison with any other sit-to-stand surface and is appropriate for his safety and mobility. Resident #17 able to propel wheelchair and manage all parts without physical assistance or cues.<br>2. Resident #17 was evaluated by Unit Manager on 5/29/18 with the restraint/device tool assessment.<br><br>• The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Therapy/Physical | |

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| F 604 | Continued From page 10<br>The goal of the care plan was Resident #17 would be free of falls with minor injury. The interventions read in part, on 04/06/18 Resident #17 had an unwitnessed fall and indicated the facility would try the rock and go wheelchair.<br><br>An observation and interview was conducted with Resident #17 on 04/30/18 at 9:47 AM. Resident #17 was sitting in a rock and go wheelchair in which the seat was slanted backwards and the backrest was in the reclined position. Resident #17 stated "can you please get me a new chair, I don't like this one."<br><br>An observation and interview was conducted with Resident #17 on 05/01/18 at 9:27 AM. Resident #17 was sitting in a rock and go wheelchair in which the seat was slanted backwards and the backrest was in the reclined position. Resident #17 stated he did not like the wheelchair he was in because he could not get out of it like he could his old wheelchair. Resident #17 indicated that he was placed in the rock and go wheelchair because he was roaming the halls too much and he had fallen. Resident #17 further indicated that he could not move the rock and go wheelchair, and placed his feet on the floor and attempted to move the large wheels with no success.<br><br>An observation was made of Resident #17 on 05/02/18 at 9:44 AM. He was ambulating with Restorative Aide (RA) #1 and #2. Resident #17 had a rolling walker and his gait was steady. RA #2 was pushing the rock and go wheelchair behind Resident #17 as he ambulated down the hall.<br><br>An observation of Resident #17 on 05/02/18 at 12:30 PM. Resident #17 was sitting at the front | F 604 | Therapist have evaluated all current facility residents with a Rock and Go Wheelchair for ability to stand on 5/8/18. No other current residents have a Rock and Go Wheelchair.<br>2. The Director of Therapy/Physical Therapist initiated in service education on 5/23/18 for all therapy staff regarding evaluation of any resident for a restraint in regards to using a Rock and Go Wheelchair.<br><br>• The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Therapy/Physical Therapist will audit all resident in Rock and Go Wheelchair for a restraint 2 x week x 4 weeks, then 1 x week for 4 weeks, then 1 x a month for 3 months.<br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br>3. The in service education will be provided during orientation for newly hired nursing staff.<br><br>• The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 604 | Continued From page 11 | F 604 | | |

door of the facility in his rock and go wheelchair with the seat slanted backwards and the backrest in the reclined position. He was attempting to roll himself out the door but was unable to move more than an inch at a time. Resident #17 was agitated and stated, "please please take me out of here they are holding me hostage in here."

An observation of Resident #17 was made on 05/02/18 at 4:03 PM. Resident # 17 was sitting in the door way of his room in a rock and go wheelchair with the seat slanted backwards and the backrest in the reclined position. He remained agitated and kept hollering for the police.

An interview was conducted with Nursing Assistant (NA) #1 on 05/02/18 at 4:39 PM. NA #1 stated she cared for Resident #17 and was familiar with him. She stated that Resident #17 was not able to get up from the rock and go wheelchair without assistance. She added that he could pull himself up using a grab bar and stated that he was able to propel himself in the rock and go wheelchair but it was very slow and in very small distances so generally the staff would have to push him where ever he needed to go.

An interview was conducted with RA #2 on 05/03/18 at 11:48 AM. RA #2 stated that Resident #17 was on restorative caseload for ambulation and exercise. She indicated that Resident #17 could ambulate independently but he was unsteady and so for safety he was assisted. RA #2 stated that he could move his rock and go wheelchair but in very small distances and stated Resident #17 was unable to get up from the rock and go wheelchair because the seat was slanted backwards and the backrest was in the reclined position. She added that they could not put

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Resident #17 in a regular wheelchair because he would get up and fall and since being in the rock and go wheelchair, he has had a decrease in his falls.

An observation of Resident #17 was made on 05/03/18 at 3:30 PM. Resident #17 was noted to be sitting in a rock and go wheelchair in the doorway of his room. The seat of the wheelchair was slanted backwards and the backrest was reclined.

An interview was conducted with the Director of Nursing (DON) on 05/03/18 at 4:14 PM. The DON stated that when Resident #17 was first admitted to the facility he was in an electric wheelchair and he became very unsafe in that and had to be placed in a manual wheelchair. She added that therapy worked with him and tried different chairs but could not find one that suited him. The DON added that Resident #17's Parkinson's disease had progressed and the clinical team felt like the rock and go wheelchair was safer for him. She added that they were aware they could not restrain Resident #17 and stated he was able to propel the rock and go wheelchair himself. She added that he could not ambulate safely by himself and indicated that was how he would fall. The DON added that Resident #17 could pull himself up using a grab bar for toileting and that the RAs walked him to keep his range of motion good. She added the rock and go wheelchair was not a restraint and gave him the safety he needed, "I would rather him not fall and break something." She added therapy would have assessed him for a restraint when they evaluated him or he would not have been put in any restraint. She added that when they tried Resident #17 in the high back wheelchair

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Resident #17 continued to fall and that was why the rock and go wheelchair was assigned to him.

An interview was conducted with the Director of Therapy (DOT) on 05/04/18 at 11:46 AM. The DOT indicated that when Resident #17 was discharged from therapy on 03/21/18 they recommended something with a reclining back with a saddle cushion. She added that he required verbal cues to get up and down for safety and needed the reclining back because he had poor trunk control. The DOT added that after Resident #17 had discharged from therapy on 03/21/18 he had a fall and during the clinical meeting they discussed the rock and go wheelchair that the facility had. She stated that since the rock and go wheelchair had a reclining back the clinical team felt like it was appropriate for Resident #17 and could be used without further therapy evaluation since he had just been discharged from therapy caseload. The DOT stated she had not witnessed Resident #17 get up out of the rock and go wheelchair by himself but stated she did not think any chair was a restraint for him because on his good days he was able to get out of the other chairs he was in.

An observation and interview with Resident #17 was made on 05/04/18 at 2:44 PM. He was noted to be sitting in a rock and go wheelchair in his room with the seat slanted backwards and the backrest reclined. He stated he could not get out of this chair and proceeded to try by rocking back and forth but was not able to get up. Resident #17 stated "can you trade this chair out for another one?"

An interview with NA #2 was conducted on 05/04/18 at 2:50 PM. NA #2 stated that Resident

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| F 604 | Continued From page 14<br>#17 was not able to get up out of the rock and go wheelchair if the backrest was reclined, she stated that when he ate they raised the backrest and he was able to get up from that position. NA #2 stated that when Resident #17 was done eating the staff reclined the rock and go wheelchair backrest and from that position he was unable to get up and that kept him from falling. | F 604 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review | F 657 | | 5/31/18 |

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| F 657 | Continued From page 15<br>assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to develop and implement a care plan for 1 of 4 residents reviewed who received anticoagulant medications (Resident #72).<br><br>Findings included:<br><br>Resident #72 was admitted to the facility on 04/05/18 with diagnoses that included congestive heart failure and heart disease of coronary artery among others.<br><br>A review of Resident #72's admission Minimum Data Set (MDS) dated 04/12/18 and revealed Resident #72 to be cognitively intact while needing extensive assistance with all activities of daily living outside of eating, for which she was coded as being independent. Resident #72 was not coded as receiving an anticoagulant at the time of the comprehensive assessment.<br><br>A review of Resident #72's electronic physician orders revealed Resident #72 to be currently receiving Eliquis (blood thinner) tablet 2.5 milligram (mg) twice daily which was ordered on 04/30/18. Further review of Resident #72's electronic physician orders revealed a discontinued order for Eliquis 2.5mg by mouth two times per day, which was originally ordered on 04/26/18.<br><br>An interview with Nurse #1 on 05/03/18 at 10:14 AM who was assigned to give medications to Resident #72 revealed to her knowledge, Resident #72 had been receiving an anticoagulant for 4 days. She further reported it | F 657 | F 657 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #72. The MDS coordinator modified the MDS dated 4/12/18 on 5/3/18, to reflect the receipt of anticoagulants and submitted the corrected MDS on 5/3/18.<br><br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The MDS coordinators conducted an audit beginning on 5/3/18, to identify residents that were receiving anticoagulants, and validated that the most recent MDS assessments for those residents were coded accurately. A corrected MDS assessment was completed when identified for one resident.<br>2. The Area MDS Consultant provided in service education for the MDS coordinators on 5/23/18, regarding accurate coding of assessments.<br><br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing will review 3 | |

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| F 657 | Continued From page 16<br>was her understanding that the Director of Nursing (DON) notified the direct care floor staff or NAs of changes in medications that would require additional or special observations. She reported if the DON was unable to relay that information to the NAs, the DON would notify the nurses and then the nurses would become responsible for relaying the change in medications. She further stated if she had not heard from the DON about not speaking to the NAs, then she assumed the DON had notified the NAs of the changed medications. She then reported she felt certain the NA #1 knew Resident #72 received an anticoagulant medication.<br><br>An interview with MDS Nurse #1 on 05/03/18 at 10:59 AM revealed she updated care plans during the quarterly and annual assessments and anytime she would be made aware of a change. She reported if a resident had come into the facility and while a resident, began receiving an anticoagulant, it would cause them to immediately reassess the care plan and a new care plan with interventions in regards to the anticoagulant should be in the electronic system "within a few hours". She further stated the facility updates the MDS team every morning of new medication orders and had begun to print out the new orders on a daily basis to help them stay on top of changes in medications and resident condition.<br><br>During an interview on 05/03/18 at 11:05 AM with MDS Nurse #2 it was revealed she handled Resident #72's assessments and was responsible for changes to her care plan. She reported she was not aware Resident #72 had begun receiving an anticoagulant and stated "yes, she should" have a care plan for the use of an anticoagulant. | F 657 | MDS assessments weekly for 4 weeks then 5 monthly for 3 months, to validate accurate coding of section N0410.<br><br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br><br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 657 | Continued From page 17<br><br>During an interview on 05/04/18 at 5:22 PM with the DON, she stated it is her expectation that anticoagulants be care planned for accordingly. She further reported the anticoagulant should have been care planned when the order was received. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to ensure a resident swallowed medications after they were administered to a resident who had difficulty swallowing for 1 of 6 residents sampled for unnecessary medication review (Resident #1).<br><br>Findings included:<br><br>Resident #1 was re-admitted to the facility on 03/01/16 with diagnoses which included dysphagia (difficulty swallowing), esophageal reflux, thyroid disease, dementia and Alzheimer's disease.<br><br>A review of a care plan with a revised date of 07/23/17 indicated Resident #1 was at risk of aspiration related to oral dysphagia and required a mechanically altered diet. The goal indicated Resident #1 would have clear lungs with no signs or symptoms of aspiration and the interventions | F 658 | F 658 Deficiency Corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #1 on 3/1/18. The resident has been assessed by Speech Therapy on 3/5/18 for swallowing difficulties and cleared for safety for the current diet and medications.<br><br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Nursing provided in service education on 3/2/18 for Nurse #4 regarding checking a residents oral cavity | 5/31/18 |

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| F 658 | Continued From page 18<br>were listed in part to observe and report as needed for any signs or symptoms of pocketing of food, choking, coughing or drooling.<br><br>A review of the most recent quarterly Minimum Data Set dated 01/30/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 required extensive assistance with eating.<br><br>During an interview on 05/03/18 at 7:22 AM, NA #7 stated she was called into Resident #1's room on 03/01/18 around 7:00 AM and Resident #1 had some white substance drooling from the right side of her mouth and Nurse #4 was in the room. She stated she had not been by Resident #1's room since around 3:00 AM so she had not observed the substance on Resident #1's mouth prior to 7:00 AM.<br><br>During an interview on 05/03/18 at 9:42 AM NA #2 stated she came to work on 03/01/18 at 7:00 AM and was called into Resident #1's room by a family member. She explained she entered Resident #1's room and Resident #1's neck was flexed back and she had some liquid drooling from the right corner of her mouth. She stated she and NA #4 cleaned Resident #1's face and neck and the substance looked like phlegm with particles of medication in it and it was down the side of her neck and onto her gown and her hair was matted in the substance.<br><br>During an interview on 05/03/18 at 10:51 AM, Nurse #4 explained he came to work on third shift at 11:00 PM on 02/28/18 and was assigned to give medications to Resident #1. He stated he started a medication pass around 5:00 AM on | F 658 | after medication has been administered for any substance that can be aspirated and cause the resident harm. The Director of Nursing/Unit Managers/Supervisors completed an audit of current residents and their ability to swallow medications on 5/22/18. Therapy will be notified if staff see any further swallowing issues with notification of same to as the physician and/or Nurse Practitioner.<br>2. The Director of Nursing/Unit Managers/Supervisors initiated in service education for all the nursing staff on 5/23/18 regarding proper medication administration. The in service education will be provided during orientation for newly hired staff<br><br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing/ unit managers/Supervisors will observe 5 residents for medication administration five times a week for 4 weeks, then 5 residents three times a week for 4 weeks, then 5 residents 4 times a month for 3 months for swallowing concerns.<br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. | |

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| F 658 | Continued From page 19<br>03/01/18 and went into Resident #1's room and raised the head of her bed up to 75 to 80 degrees because he was aware she was at risk for aspiration (to inhale fluid into her lungs). He stated he had crushed Resident #1's medications in applesauce and took them into Resident #1's room and gave them to her with a sip of water. He explained he watched her throat and thought she had swallowed the medications but he did not open her mouth to make sure she had swallowed them. He further explained he left Resident #1's room and around 6:30 AM a family member who routinely visited early each morning called him into the room and Resident #1 had drooling of the medication out of the side of her mouth, down the side of her neck and onto her gown. He confirmed the substance from her mouth was the medication she had not swallowed.<br><br>During an interview on 05/04/18 at 9:35 AM, NA #4 stated she came to work on 03/01/18 at 7:00 AM and was at the nurse's desk when she was called to Resident #1's room and saw a white substance from the right side of Resident #1's mouth. She explained she and NA #2 cleaned Resident #1's face and neck and described it as a white, frothy and sticky substance coming out of the right side of her mouth and her hair was matted in the substance.<br><br>During an interview on 05/03/18 at 4:14 PM the Director of Nursing stated she had observed Resident #1 during medication administration since 03/01/18 and confirmed Resident #1 did not swallow her medications. She explained it was her expectation for nurses to open Resident #1's mouth when they gave her medications to check and make sure she swallowed the medications before they left the resident's room. | F 658 | " The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews the facility failed to check a resident for incontinence care when awake (Resident #1) and the facility failed to provide nail care to a resident with jagged and long toenails (Resident #59) for 2 of 5 sampled residents for activities of daily living.<br><br>Findings included:<br><br>1. Resident #1 was re-admitted to the facility on 03/01/16 with diagnoses which included heart disease, type 2 diabetes, chronic kidney disease, dementia and Alzheimer's disease.<br><br>A review of the most recent quarterly Minimum Data Set (MDS) dated 01/30/18 indicated Resident #1 was severely impaired in cognition for daily decision making. The MDS also indicated Resident #1 was totally dependent on staff for toileting and hygiene and was always incontinent of bladder and bowel.<br><br>A review of a care plan with a revised date of 02/02/18 indicated Resident #1 had a self-care deficit for activities of daily living and a goal was listed in part to maintain current level of functioning with toilet use and personal hygiene. The interventions were listed in part to provide incontinence care due to Resident #1 was frequently incontinent and required extensive assistance with incontinence care. | F 677 | F 677 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #59 received nail care in regards to her toe nails completed on 5/4/18.<br>2. Resident #1 received incontinence care in regards to brief not being changed throughout the night on 2/28/18, incontinence care was performed on 3/1/18.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Nursing/Unit Managers/Supervisors completed an audit on all current residents for need of nail care on 5/23/18. Those residents identified from the facility audit was referred to podiatry services.<br>2. The Director of Nursing/Unit Managers/Supervisors initiated in service on 5/23/18 to all current nursing staff on provisions of nail care and notifying nurse administrators if podiatry is needed.<br>3. The Director of Nursing/Unit Managers/Supervisors initiated in services on 5/23/18 to all current nursing staff on provisions of incontinence rounds.<br>4. The in service education will be | 5/31/18 |

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| F 677 | Continued From page 21<br><br>A review of monthly physician's orders dated May 2018 indicated Lasix (caused increased passing of urine) 40 milligrams daily for heart failure.<br><br>A review of a facility document titled Summary of Information indicated on 03/01/18 at approximately 7:00 AM Resident #1's RP reported Resident #1 was not checked or changed because her brief had not been changed all night. The intervention and conclusion indicated the brief had not been changed and residents needed to be checked and changed every 2 hours and as necessary.<br><br>During an interview on 04/30/18 at 11:24 AM with Resident #1's Responsible Party (RP) she stated she usually arrived at the facility around 5:00 AM each morning but sometimes varied her times depending on what she had planned for the day. She explained she arrived at the facility on 03/01/18 at approximately 6:30 AM and noticed an odor of urine when she entered the room. She explained she looked at Resident #1's brief and saw a time of 10:40 PM written in black ink on the brief and stated another family member had visited Resident #1 the previous evening and had written the time on the brief when they had changed Resident #1's brief before she left the facility. She stated she called for Nurse #4 and NA #7 to come to the room to explain why Resident #1's brief had not been changed since second shift the previous evening and NA #2 and NA #4 who worked day shift entered the room around 7:00 AM. She further stated when NA #2 and NA #4 removed Resident #1's brief she was soiled with stool and urine. She explained Resident #1 was usually awake when she arrived at the facility at 5:00 AM and she would have | F 677 | provided during orientation for newly hired staff<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing/Unit Managers/Supervisors will observe 5 residents 5 x a week for 4 weeks, then 5 residents 3 x week for 4 weeks, then 5 residents monthly x 3 month to validate nail care is being completed in the facility and appropriate referrals made for podiatry.<br>2. The Director of Nursing/Unit Managers/Supervisors will observe 5 residents 5 x week for 4 weeks, then 5 residents 3 x week for 4 weeks, then 10 residents a month x 3 months to validate incontinence care rounds.<br>3. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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expected for Resident #1 to have been cleaned and changed before 6:30 AM. She stated she did not want Resident #1's skin to break down and she wanted staff to keep Resident #1 clean and dry and felt her brief should have been changed before 6:30 AM. She further stated Resident #1 was awake when she arrived on 03/01/18 and it was her expectation for the NAs to check Resident #1 during the night even if they woke her because she usually went back to sleep.

During an interview on 05/02/18 at 3:46 PM, Nurse Aide (NA) #5 stated she had provided care to Resident #1 on second and third shifts prior to 03/01/18. She described Resident #1 as a heavy wetter when she had provided incontinence care for her and nurse aides (NAs) were expected to check and change residents every 2 hours but if a resident was asleep they usually went back later when the resident was awake.

During an interview on 05/03/18 at 7:22 AM, NA #7 confirmed during the night shift on 03/01/18 she was assigned to provide care to Resident #1 and was walking past her room around 12:30 or 1:00 AM and saw Resident #1 sitting at the foot of her bed with her feet on the floor. She stated she repositioned Resident #1 and checked her and she was dry but she noticed a time of 10:40 PM was written on the brief from second shift the night before. She explained she was aware Resident #1's family sometimes changed her brief and when they did they wrote the time on the brief so staff would know when they had last changed it. She further explained she walked by Resident #1's room around 3:00 AM to make sure she was in bed but did not check Resident #1. She stated she could not recall if Resident was awake or asleep at that time. She further

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stated she provided care to other residents after 3:00 AM but did not go back into Resident #1's room until she was called into Resident #1's room around 7:00 AM and did not know when Resident #1 woke up on 03/01/17.

During an interview on 05/03/18 at 9:42 AM, NA #2 explained Resident #1 had family who visited during the day shift and evening shift and when they visited they sometimes changed Resident #1's brief and when they did without staff assistance they wrote the time they changed it on the brief to let staff know when they had last changed it. She stated she came in to work at 7:00 AM on 03/01/18 and was called into Resident #1's room because Resident #1's family was in the room and stated Resident #1 had not been cleaned during the night shift. She stated she and NA #4 checked Resident #1's brief and it had a blue stripe on it which indicated the brief was wet and when they removed Resident #1's brief it was wet and soiled with stool. She confirmed Resident #1's brief contained a large amount of urine and stool that was dried and stuck to Resident #1's skin and her skin was red. She explained they could not determine how long Resident #1's brief had been soiled but the stool looked dried around the edges and thought it had been there awhile. She stated after they provided care to Resident #1, NA #7 was at the nurse's desk and stated it was her routine to check residents once during the night on third shift.

During an interview on 05/03/18 at 10:51 AM, Nurse #4 stated he came on shift at 11:00 PM on 02/28/18 and around midnight NA #7 called him into Resident #1's room. He explained he went into Resident #1's room and she was sitting on the side of the bed so he and NA #4 repositioned

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Resident #1 in bed and NA #7 checked Resident #1's brief and said it was dry but he did not look to verify if it was dry. He stated around 5:00 AM he started his morning medication pass and Resident #1 was awake and he gave her medication but did not notice if there was an odor of urine or stool when he was in the room. He explained around 6:30 AM a family member who routinely visited with Resident #1 each morning arrived at the facility and complained Resident #1's brief was wet and her brief had not been changed since second shift the evening before. He stated he went into Resident #1's room and she had a brief on with a time written on it at 10:40 PM and he had wondered why Resident #1 had the same brief on from the evening before. Nurse #4 stated he asked NA #7 if she had changed Resident #1 during the night and was told she checked each resident once during the night shift and she had not gotten around to changing Resident #1 before she finished her shift at 7:00 AM on 03/01/18. He stated Resident #1 was not able to call for staff assistance with her call bell but relied on staff to check on her. He further stated it was his expectation for NAs to make rounds to make sure residents were not lying in urine or stool for an extended period.

During an interview on 05/04/18 at 9:35 AM, NA #4 explained she came in to work on 03/01/18 at 7:00 AM and a family member of Resident #1 requested for NA #7 and Nurse #4 to come to Resident #1's room. She stated she and NA #2 also went to Resident #1's room and a family member was present. She confirmed she and NA #2 checked Resident #1's brief and she was wet and had stool which was stuck to her skin but was unsure how long her brief had been soiled with urine or stool.

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During an interview on 05/04/18 at 5:52 PM the Director of Nursing (DON) stated it was her expectation that NA #7 should have checked Resident #1 around 5:30 or 6:00 AM since she had checked the resident around 3:00 AM. She further stated it was her expectation for NAs to make rounds before they finished their shift to make sure residents were clean and dry and expected for them to check and change residents when they woke up.

During an interview on 05/04/18 at 7:08 PM, the Administrator stated it was his position for staff to provide care to residents to ensure they were kept clean and dry and he expected the same as the DON expected.

2. Resident #59 was admitted to the facility on 06/03/16 with diagnoses that included: hemiplegia, osteoporosis, cerebral infarction, and vascular dementia.

Review of a comprehensive Minimum Data Set (MDS) dated 04/03/18 revealed that Resident #59 was severely cognitively impaired and required total assistance of one staff member with personal hygiene.

An observation was made of Resident #59 on 05/01/18 at 9:53 AM. Resident #59 was resting in bed covered with a sheet with her feet hanging out. Her bilateral great toe nails plus 5 other toe nails (2 on right foot and 3 on left foot) were approximately a quarter inch long and were jagged.

An observation was made of Resident #59 on 05/02/18 at 11:08 AM. Resident #59 was resting

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in bed with eyes open. She removed her socks and the sock got caught on the great toe nail of her left foot. Her bilateral great toe nails and 5 other toe nails (2 on right foot and 3 on left foot) remained a quarter inch long and jagged.

An observation was made of Resident #59 on 05/03/18 at 11:45 AM. Resident #59 was resting in bed with her legs propped up. Resident #59 removed her socks and when she did her sock caught on her toe nail of her left great toe. Her bilateral great toe nails and 5 other toes nails (2 on right foot and 3 on the left foot) remained a quarter inch long and jagged.

An observation and interview was conducted with Nurse #3 on 05/03/18 at 2:51 PM. Nurse #3 observed Resident #59's toe nails and confirmed that they were a bit long and jagged and definitely needed to be trimmed and/or filed. She stated that the Nursing Assistants (NAs) were not able to trim toe nails and all they had to do was report that they needed to be trimmed and she would handle it. Nurse #3 stated that no one had brought to her attention that Resident #59's toe nails were long and jagged.

An interview was conducted with NA #2 on 05/03/18 at 2:52 PM. She confirmed that she was caring for Resident #59. NA #2 stated that she had noticed Resident #59's long and jagged toe nails but had not notified the nurse. She stated she was going to have the staff place Resident #59 on the list to see the podiatrist the next time he came to the facility but she was not sure when that was. NA #2 further explained that nail care was to be provided during the shower and any time it was needed. She added that NAs were not allowed to trim toe nails, they were instructed to

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| F 677 | Continued From page 27<br>report that to the nurse who would attempt to trim them.<br><br>An interview was conducted with Resident #59's family member on 05/03/18 at 3:00 PM. The family member stated that she had trimmed her family member toe nails about 6-8 weeks ago because they were long and she had asked someone to trim them each time she had a shower but she could tell that was "obviously not being done." The family was unable to recall who she had spoken to about the nails.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/03/18 at 4:14 PM. The DON stated that she expected the staff to perform nail care during the resident's shower and daily when providing care. She stated she expected the staff to report it to the nurse when they noticed Resident #59's toe nails were long and jagged so the nurse could trim them or obtain a referral to the podiatrist. | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent | F 686 | | 5/31/18 |

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| F 686 | Continued From page 28<br>new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, staff interviews, and Wound Doctor interview the facility failed to correctly transcribe a treatment that was ordered twice a day and apply the correct treatment to a Stage 4 sacral wound for 1 of 3 residents sampled for pressure ulcers (Resident #5).<br><br>The findings included:<br><br>Resident #5 was initially admitted to the facility on 05/29/15 and most recently readmitted to the facility on 01/26/18. His diagnoses included acquired absence of left leg and diabetes mellitus.<br><br>Review of the most recent quarterly Minimum Data Set (MDS) dated 04/18/18 revealed that Resident #5 was cognitively intact for daily decision making and rejection of care occurred 1 to 3 days during the assessment period. The MDS also revealed that Resident #5 required extensive assistance with activities of daily living and had an unstageable pressure ulcer, which was not present on admission and indicated Resident #5 received pressure ulcer care.<br><br>Review of a Wound Care Specialist Evaluation dated 04/26/18 indicated that Resident #5 had a Stage 4 pressure ulcer to his sacral area that measured 8.0 centimeters (cm) by 6.2 cm by 0.6 cm. The evaluation also indicate that the wound was 80% devitalized necrotic (dead) tissue and 20% black necrotic tissue. The recommended treatment for the Stage 4 sacral wound was to clean the wound with normal saline and apply | F 686 | F 686 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #5 received the correct wound care treatment on 5/3/18.<br>2. On 5/4/18 the wound care physician discontinued order for twice daily dressing change to once daily dressing change and is was properly transcribed into the medical record.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Nursing conducted an audit of all current wound care orders provided by the wound care physician and validate the orders have been transcribed correctly to the electronic treatment record on 5/4/18.<br>2. The Director of Nursing/Unit managers initiated in services with current nursing staff on 5/23/18 on transcribing the correct wound treatment to the electronic treatment record.<br>3. The in service education will be provided during orientation for newly hired licensed nursing staff.<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. Director of Nursing/Unit managers will audit the wound physician orders weekly | |

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mupirocin (antibiotic ointment) ointment and cover with a foam dressing twice daily.

Review of a physician order dated 04/26/18 read, clean sacral wound with normal saline, apply mupirocin to wound bed and cover with foam dressing every day.

Review of the treatment administration record dated 04/01/18 through 04/30/18 revealed the following, clean sacral wound with normal saline then apply mupirocin to wound bed and cover with foam dressing daily. The treatment had been initialed daily from 04/27/18 through 4/30/18.

Review of the treatment administration record dated 05/01/18 through 05/31/18 revealed the following, clean sacral wound with normal saline then apply mupirocin to wound bed and cover with foam dressing daily. The treatment had been initialed daily from 05/01/18 through 05/04/18.

An observation of wound care was made with Nurse #4 on 05/02/18 at 3:53 PM. Nurse #4 gathered his supplies and entered Resident #5's room. Upon entering Resident #5's room, Nurse #4 explained to Resident #5 that he was going to perform wound care to his sacral wound. Resident #5 then stated, "no Nursing Assistant (NA) #2 had already done the treatment." Nurse #4 stated ok and exited the room.

An interview was conducted with Nurse #4 on 05/02/18 at 4:00 PM. Nurse #4 stated that earlier on the shift at around 1:30 PM, NA #2 had provided incontinent care to Resident #5 and his dressing had become dislodged. He stated that NA #2 had stated to him that Resident #5 needed a new dressing. Nurse #4 stated he was in the

for correct transcribing to the electronic treatment record x 3 months.
2. The Director of Nursing/Unit Managers will observe 4 residents receiving pressure ulcer wound treatments 4 times a week for 4 weeks, then 2 a week x 4 weeks, then randomly observed monthly x 3 months.
3. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.

" The title of the person responsible for implementing the acceptable plan of correction:
1. The Administrator

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middle of passing medications so he gave NA #2 a foam dressing to apply to the wound and stated he would return later to apply the correct treatment of mupirocin. Nurse #4 stated that Resident #5 does not usually refuse treatment care and Resident #5 assumed that NA #2 had already done the treatment and that is why he did not want Nurse #4 to redo the treatment. Nurse #4 stated he did not explain to Resident #5 that NA #2 had only covered the wound and he needed to apply the correct treatment because he did not want to upset Resident #5.

An interview with NA #2 was conducted on 05/03/18 at 9:43 AM. NA #2 state that on 05/02/18 she had provided incontinent care to Resident #5 and his sacral dressing was soiled and became dislodged. She stated she went to Nurse #4 and told him that the dressing had come off and Resident #5 needed a new dressing. She added that Nurse #4 replied, "I was planning on doing that dressing later" and handed me a foam pad to cover the wound with. NA #2 state that the foam dressing she had applied on 05/02/18 had come off again this morning 05/03/18 with incontinent care and she again had told Nurse #4 that the wound needed a new dressing.

An observation of wound care was made on 05/03/18 at 2:41 PM. When Resident #5 rolled onto his side to expose the wound which was not covered with a dressing at the time. Nurse #4 proceed to clean the wound and apply mupirocin ointment and cover it with a foam dressing. Resident #5 tolerated the dressing change well and thanked Nurse #4 before he exited the room.

An interview was conducted with the Director of

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| AVANTE AT WILKESBORO | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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| F 686 | Continued From page 31 | F 686 | | |

Nursing (DON) on 05/03/18 at 4:14 PM. The DON stated that she rounded with the Wound Doctor (WD) weekly and following their visits they went over each wound. The DON stated that the WD would verbally go over each order and she would enter them into the electronic system. She stated she must have checked the wrong button when entering the frequency of the treatment for Resident #5's sacral wound to indicate once a day instead of twice a day like the WD recommended. She added that the hall nurses do not enter any orders into the system she entered them all herself and any errors would be hers, "that way she knew was going on".

A follow up interview was conducted with Nurse #4 on 05/03/18 at 2:57 PM. Nurse #4 stated that Resident #5 received daily dressing changes to his sacral wound. He added that the DON rounded with the wound doctor and she entered all the orders into the electronic system and that was how he knew which treatment he needed to do and when he needed to do them.

An interview was conducted with the WD on 05/04/18 at 2:59 PM. The WD indicated that Resident #5's wound had been actively deteriorating for 3 weeks because he had an active wound infection. He added that initially the wound was small in size and the next week the wound was red and Resident #5 was complaining of pain to the area. The WD stated he made the decision to get aggressive with the wound and debrided the wound and cultured it. The culture revealed the active wound infection and Resident #5 was placed on intravenous (IV) antibiotics. The WD stated that since then, the overall wound has shown signs of improvement and when he visited him on 05/04/18 there was no wound odor

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| F 686 | Continued From page 32<br>which was a good indication that the infection was improving. He added that he expected that the treatment he recommended was the treatment that was used. The WD added that the wound was showing improvement and he had again changed the treatment order on 05/04/18.<br><br>A follow up interview was conducted with the DON on 05/04/18 at 6:26 PM. The DON stated that she would expect Nurse #4 to finish what he was doing and then go and apply the correct treatment to Resident #5's sacral wound. She added the nurse should get to stopping point and then go and apply the ordered treatment. | F 686 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident, family, staff, and Wound Doctor interviews the facility failed to eliminate sharp metal edges of a resident's wheelchair that would prevent a skin tear from occurring. The skin tear resulted in the resident requiring multiple wound debridement's (the removal of damaged tissue) for 1 of 2 residents sampled for non-pressure related wounds (Resident #67).<br><br>The findings included: | F 689 | F 689 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #67 incident of receiving a skin tear to her right lower leg while being transferred from the shower chair to her wheelchair in the shower room on 3/20/18. Resident #67 wheelchair was inspected for sharp metal edges none | 5/31/18 |

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| F 689 | Continued From page 33<br><br>Resident #67 was admitted to the facility on 02/09/18 and most recently readmitted to the facility on 04/21/18 with diagnoses that included: urinary tract infection, myocardial infarct, chest pain, weakness, and hypertension.<br><br>Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/16/18 revealed that Resident #67 was cognitively intact and required extensive assistance with activities of daily living. Skin tears were not checked on the MDS assessment.<br><br>Review of an "Investigation for skin tears or bruise" dated 03/20/18 at 6:13 PM read in part, description of injury: Resident #67 was in the shower room and was standing beside her wheelchair and hit the side of her wheelchair and tore the skin on her right lower leg. The skin tear was dressed and wrapped with gauze. Leg protector was placed on right leg to prevent future occurrences. Skin condition was listed as fragile with previous skin tears noted. The form was signed by Nurse #1. The investigation results read, no further investigation needed. Skin tear occurred during transfer to wheelchair from shower chair. This was signed by the Director of Nursing (DON).<br><br>Review of a care plan that was initiated on 04/16/18 read, Resident #67 has the potential for skin integrity impairment. The care plan indicated that Resident #67 had skin tears to her right superior lateral leg, right inferior lateral leg, left lateral leg, and right superior shin area. The goal of the care plan read, Resident #67 will be free from skin tears through the review period and her skin tear of the left leg would be healed by the | F 689 | found, only the wheelchair leg connector brackets that are rounded and free from any sharp edges. In addition Resident #67 has been given a brand new wheelchair on 5/22/18.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Maintenance/Maintenance Assistant completed an audit on 5/23/18 of all facility wheelchairs inspecting for any sharp metal edges any repairs needed was completed by maintenance. The Director of Maintenance/Maintenance Assistant will inspect wheelchair for sharp edges during regular routine inspection and cleaning. All wheelchairs in use in rooms 100 through 139 will be inspected and/or cleaned during 1st two weeks of each month and all wheelchairs in use in rooms 140 thorough 160 will be inspected and/or cleaned during 2nd two weeks of each month by Director of Maintenance/Maintenance Assistant.<br>2. The Administrator/Director of Maintenance initiated in service education on 5/23/18 for all staff regarding proper notification of any defected wheelchair parts, with notification through the TELS system in Point Click Care.<br>3. The in service education will be provided during orientation for newly hired 1staff.<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: | |

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| F 689 | Continued From page 34<br>review date. The interventions listed read in part, if a skin tear occurred treat per facility protocol and notify the medical doctor, keep skin clean and dry, use lotion on scaly skin, use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface.<br><br>An interview and observation was conducted with Resident #67's family member on 04/30/18 at 11:18 AM. Resident #67's family member stated that she has had 4 incidents of getting her leg cut on her wheelchair. She stated that this past weekend the facility had started using the lift to transfer her family member and indicated that the lift was the only protective measure they have used since the injury to her right leg that occurred on 03/20/18. She added that the wound was not looking good and had to be seen by the Wound Doctor (WD). The family member stated she had spoken to several staff members but could not recall who they were. The family member further stated she had asked about what they were going to do to protect her family members legs and she has never gotten clear answers. Resident #67's wheelchair was observed to be sitting next to her bed and there were 2 small sharp pieces of metal on each side of the wheelchair where the leg rest were supposed to attach to the chair. The metal sides of the wheelchair and lower frame where visible.<br><br>An observation was made of wound care on 05/02/18 at 4:12 PM with Nurse #3. Nurse #3 removed the old dressing to the right lateral lower leg and cleaned the wound. The wound was long with a beefy red wound bed. The skin tear was cleaned and calcium alginate applied and covered with a foam dressing and Nurse #3 | F 689 | 1. The Administrator/Director of Maintenance/Maintenance Assistant will conduct audits of 5 resident wheelchairs 5 x a week x 4 weeks, then 3 resident wheelchairs 3 x times a week for 4 weeks, then 1 resident wheelchair 1 x a week for a month.<br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br><br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 689 | Continued From page 35 | F 689 | | |

exited the room. Resident #67's wheelchair was observed to be sitting next to her bed and there were 2 small sharp pieces of metal on each side of the wheelchair where the leg rest were supposed to attach to the chair. The metal sides of the wheelchair and lower frame where visible.

An interview was conducted with the Wound Doctor (WD) on 05/04/18 at 3:17 PM. The WD stated that when he first began to see Resident #67 she had a large wound to her right lower leg and was also suffering from stasis dermatitis (skin inflammation in the lower legs caused by fluid buildup) and he started compression dressings to her lower legs. The WD stated that there was a divot or hole in the wound and initially he did not probe into the hole but on subsequent visits he did probe into the hole and was very certain this wound was related to trauma from the wheelchair. He added that on his first visit with Resident #67 he had to clean the wound up by surgically debriding the wound and removing the slough (dead) tissue so the wound could begin to heal. He added that he had also debrided the wound several more times since then. The wound to Resident #67's right lower leg was trauma related and the WD stated "she gets trauma wounds a lot." The WD stated that the right lower leg had required several surgical debridement but was doing well and he expected it to heal in the next 2 weeks.

An interview was conducted with Resident #67 on 05/04/18 at 4:13 PM. Resident #67 stated on 03/20/18 she was in the shower room with the staff and after they had completed the shower they pulled the wheelchair up beside the shower chair instead of up behind her and that caused her to bump her leg. Resident #67 stated that she

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| F 689 | Continued From page 36 | F 689 | | |

had told numerous staff members that when they transfer her they must put the wheelchair directly behind her but indicated each time she received her shower it was someone different. She could not recall if she had told NA #3 about that before or after the skin tear occurred. She pointed at the wheelchair and stated it was the part of the wheelchair where the leg rest connected to the wheelchair. Resident #67 stated that they did not pay attention to what they were doing but now they were more careful and "pull the chair up behind me so I all I have to do is sit down". Resident #67 stated that skin tear bled a lot but really did not cause her pain. She stated the staff was wrapping her bilateral lower legs with ace bandages to help with the swelling and indicated that she had not seen any padding to her wheelchair since the incident.

An attempt to speak with Nurse #1 on 05/04/18 at 5:04 PM was unsuccessful.

An interview was conducted with the Director of Nursing (DON) on 05/04/18 at 5:33 PM. The DON stated that Nurse #1 had completed the "Investigation for skin tears or bruise" dated 03/20/18 and then she entered them into the facility's electronic record system and provided any additional follow up that was needed. The DON stated that from her understanding NA #3 was giving Resident #67 a shower and had finished the shower and gotten her completely dressed and while transferring her back to her wheelchair Resident #67 stood up and went to sit down in her wheelchair and bumped her leg on the wheelchair. She added that Resident #67's legs were "like a ripe melon and you can barely touch them." The DON stated that NA #3 went and reported it to Nurse #1 who clean and

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| F 689 | Continued From page 37 | F 689 | | |

dressed the wound and notified the family and the medical provider. In this case the DON stated it was pretty clear cut and the root cause was she bumped her leg during a transfer and no further follow up was required. The DON stated that after the Wound Doctor (WD) visited with Resident #67 the facility added the shin guards but she was not currently wearing them because her legs were being wrapped with ace bandages. The DON stated that on 03/21/18 she went to look at the skin tear because it was a "bad skin tear that had an indentation from the piece on the wheelchair." The DON stated that prior to this incident she could not recall any specific intervention that was in place to protect Resident #67's skin but since the incident they were wrapping her bilateral lower legs with ace bandages to help with the edema and recently they had started using the mechanical lift for her transfers. She also believed that they had added some padding to the wheelchair brake handles for protection. The DON stated she expected the staff to be as careful as possible with Resident #67 because her skin was so fragile.

An interview was conducted with the Director of Maintenance (DOM) on 05/04/18 at 5:43 PM. The DOM stated he had not received any request to make any modifications or padding to Resident #67's wheelchair

An interview was conducted with Nursing Assistant (NA) #3 on 05/05/18 at 11:58 AM. NA #3 stated that on 03/20/18 she was responsible for giving Resident #67 a shower, she indicated this was not her first time showering Resident #67 and she was familiar with her and her needs. NA #3 stated that she had pushed Resident #67 into the shower room in her wheelchair and she had

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| F 689 | Continued From page 38<br>transferred her to the shower chair. She added she was able transfer by standing up using the grab bar and pivoting to the shower chair. NA #3 stated that Resident #67 did a good job of using the grab bar to pull herself up to the standing position. She added that she placed Resident #67 in the shower chair and proceeded to give her a shower. After the shower she had helped Resident #67 dry off and get dressed for bed. She indicated that she had pulled the wheelchair up beside Resident #67 and she pulled up on the grab bar and pivoted back to her wheelchair. NA #3 stated that somehow, she bumped her leg on the wheelchair and it caused a skin tear. She added that the part of the wheelchair that Resident #67 bumped her leg on was the 2 small sharp metal pieces where the leg rest connected to her wheelchair and to her recollection there was no padding to that part of the wheelchair. She indicated that there was quite a bit of blood and she immediately went and got Nurse #1 who came to the shower room and cleaned and dressed the skin tear. NA #3 stated that currently Resident #67 was not wearing any leg protector because her lower legs had bandages on them and she was very careful when she transferred Resident #67 now. NA #3 stated that Resident #67 requested that the staff place her wheelchair directly behind her so all she had to do was sit down, and that seems to be helping as well. NA #3 could not recall seeing any padding to Resident #67's wheelchair since the incident. | F 689 | | |
| F 697 SS=G | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, | F 697 | | 5/31/18 |

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| F 697 | Continued From page 39<br>consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff and medical doctor (MD) interviews, the facility failed to manage the pain of 1 of 1 resident (Resident #6) reviewed for Hospice services.<br><br>The findings included:<br><br>Resident #6 was admitted to the facility on 09/18/12 and readmitted on 03/28/18 with diagnoses which included acute and chronic respiratory failure with hypoxia, diabetes, chronic pain, peripheral vascular disease (PVD) and unstageable pressure ulcers.<br><br>A review of a note written by the Minimum Data Set (MDS) nurse on 02/01/18 revealed during a pain interview Resident #6 revealed she had pain frequently, mostly in her head and neck. Her pillow was repositioned and it helped some but Resident #6 stated her pain was at a level 8 out of 10.<br><br>A review of the Significant Change Minimum Data Set (MDS) dated 02/10/18 revealed Resident #6 had moderately impaired cognition for daily decision making but was able to make her needs known. The MDS also revealed Resident #6 required extensive assistance of 1 to 2 persons with most activities of daily living (ADL), had a catheter due to a sacral pressure ulcer and was incontinent of stool. The MDS revealed Resident #6 received scheduled and as needed (PRN) pain medication for frequent pain at a level 8 on a scale of 1 to 10. | F 697 | F 697 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #6 in regards to pain management was assessed for the need for increased pain regiment and an order received from Mt. Valley Hospice on 5/3/18 to increase the resident□s Fentanyl patch from 100mcg to 150mcg, the new fentanyl 150mcg administered on 5/4/18 as well as continuing the Morphine 5mg Q1hr prn.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Nursing/Unit managers completed an audit all current in house hospice residents for pain management on 5/21/18 and reviewed their current pain regiment for adequate pain control.<br>2. The Director of Nursing/Unit managers initiated in service education on 5/23/18 on all current nursing staff on assessing Hospice residents pain using both verbal/non-verbal indicators.<br>3. The in service education will be provided during orientation for newly hired staff<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains | |

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| F 697 | Continued From page 40<br><br>A review of the Care Area Assessment (CAA) summary dated 02/15/18 revealed Resident #6 was under Hospice care as of 01/19/18 for acute and chronic respiratory failure with hypoxia. The resident has a history of chronic pain and received Fentanyl patch and prn morphine sulfate (MS) was ordered every 2 hours prn pain. She had an air mattress on her bed and had pressure areas to her toes, heel sacrum and shins.<br><br>A review of Resident #6's care plan dated 02/20/18 revealed she had a care plan for acute and chronic pain related to arthritis, chronic pain syndrome and immobility. The goal was Resident #6 would verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the next review date. The orders included: administer analgesia as per orders, anticipate need for pain relief and respond immediately to any complaints of pain, evaluate the effectiveness of pain interventions approximately 30 minutes to 1 hour post intervention and review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, monitor/record pain characteristics, quality, severity, location, onset, duration, aggravating factors and relieving factors, monitor/record any signs or symptoms of non-verbal pain such as changes in breathing, vocalizations, mood/behavior changes, eyes, face, and body, monitor/report to nurse resident complaints of pain or requests for pain treatment, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, remind resident to call for assistance when in pain and needing repositioning or medication, and report to nurse any change in usual activity attendance | F 697 | corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing/Unit Managers will observe 3 Hospice residents 5 x week for 4 weeks, Then 5 Hospice residents 3x week for 4 weeks, then 5 Hospice residents a month for 3 months to validate current pain regiment is adequate to control their pain.<br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br><br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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patterns or refusal to attend activities related to pain or discomfort.

A review of Resident #6's current physician orders for May, 2018 revealed orders for Morphine sulfate (MS) 0.25 milliliters (ML) or 5 milligrams (MG) by mouth every 1 hour as needed for pain (effective 04/02/18), Ativan 1 mg by mouth every 2 hours as needed for anxiety - may give via gastrostomy tube, Lorazepam 1 mg tablet by mouth three times daily for anxiety - may give via gastrostomy tube and Fentanyl Patch 72 hour 100 micrograms (MCG) per hour - apply trans-dermally one time a day every 3 days for pain.

An observation of Resident #6's dressing change to her pressure ulcers on 05/02/18 at 10:40 AM revealed Nurse #2 and Nurse #6 in to change dressings to right calf, right medial heel, and left medial heel. As Nurse #2 starting positioning Resident #6 for the dressing changes, the resident was crying and her eyes were clinched and face grimaced and she stated her head, neck, shoulders and both legs were hurting. Nurse #2 continued with the dressing change to the resident's right calf and right medial heel as the resident continued with grimaced face and crying in pain. There was a dressing on the resident's left medial heel which was new and Nurse #2 stated she did not have orders and would need to talk with the Director of Nursing about the dressing and left the room. Nurse #6 told Resident #6 she would check to see if she could have something for pain and left the room. Resident #6 stated her pain was a level 9 out of 10. Nurse #6 returned to the room with Morphine sulfate (MS) 0.25 ml or 5 mg and gave the resident the medication via oral route in the side

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of her mouth at 10:50 AM. Nurse #2 came back into the room and changed the dressing on the resident's left medial heel.

A review of Resident #6's Medication Administration Record (MAR) revealed she had not been medicated with MS 5 mg vial oral route since 05/01/18 at 11:00 PM.

An observation of Resident #6 on 05/03/18 at 2:30 PM being cleaned up by Nurse Aide (NA) #8 and NA #5 after her feeding tube had leaked all over her and her bed revealed the resident with grimaced face, clinched eyes, crying and stated "oh please help me honey, it hurts so bad." Resident #6 stated her pain was at a level 10 out of 10 and continued crying in pain. The NAs placed Resident #6 on her back and were cleaning under her abdominal fold and under her breasts and the skin was red, shiny and irritated and the resident was red in the face, crying and stated "oh that hurts." Resident #6 stated her skin was extremely irritated and when they rubbed on it to clean it, "it really hurt badly." NA # 5 left the room to get the nurse to come and apply medicated powders to the resident's skin folds. Nurse #2 came into the room and applied medicated powder to her irritated skin folds and assessed the resident for pain and told her she would bring her back some medication for pain. Nurse #2 returned to the room and medicated the resident with MS 5 mg via oral route in the side of her mouth at 2:30 PM.

A review of Resident #6's MAR revealed she had not been medicated with MS 5 mg via oral route since 05/03/18 at 8:39 AM.

An observation of Resident #6 on 05/04/18 at

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11:58 AM revealed her in bed with her oxygen on via nasal cannula and her feeding tube infusing via pump at 25 milliliters per hour and the resident had grimaced face and was moving in her bed and stated her pain was a level 10 out of 10. Resident #6 stated she had some pain medication earlier but it had not helped her pain and it was still a level 10. The resident's pain level was reported to her nurse.

A review of Resident #6's MAR revealed she had been medicated on 05/04/18 at 9:50 AM with MS 5 mg via oral route.

A review of the Medication Administration Record (MAR) revealed Resident #6 had Fentanyl Patch 100 mcg per hour placed on 05/01/18 at 2:18 PM. The MAR also revealed Resident #6 had received Morphine sulfate (MS) 0.25 ml or 5 mg on 05/01/18 at 3:37 PM for pain level of 5 with documented effectiveness, and at 11:00 PM for pain level of 5 with effectiveness. On 05/02/18 the resident received MS 5 mg at 10:50 AM for pain level of 9 with effectiveness at level 1 and again at 11:50 AM for pain level of 8 with documented effectiveness. On 05/03/18 the resident received MS 5 mg at 8:39 AM for pain at level 4 with effectiveness and at 2:30 PM for pain level of 10 with documented effectiveness and on 05/04/18 the resident received MS 5 mg at 09:50 AM for pain level of 6 with documented effectiveness, at 2:27 PM for pain level of 3 with documented effectiveness and at 3:53 PM for pain level of 6 with documented effectiveness. The order was written for the resident to have 0.25 ml or 5 mg of MS every 1 hour as needed for pain; however, the resident only averaged getting the medication 2 to 3 times per day.

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| F 697 | Continued From page 44<br>An interview with NA #8 revealed she had been trained to notify the nurse immediately when a resident complained of pain during care.<br><br>An interview with Nurse #2 on 05/03/18 at 2:44 PM revealed she had called Hospice on 05/02/18 about increasing Resident #6's pain medication and stated the Hospice nurse had been at the facility on 05/02/18 and talked about increasing her pain medication but had not changed the orders. Nurse #2 stated she would call again and ask about getting her pain medication increased by Hospice.<br><br>A review of Resident #6's chart on 05/04/18 revealed an order had been written to increase the Fentanyl Patch from 100 mcg to 150 mcg per hour every 72 hours.<br><br>A phone interview on 05/04/18 at 5:19 PM was attempted with the Hospice nurse with no return call received.<br><br>An interview on 05/04/18 at 6:24 PM with the Director of Nursing (DON) revealed her expectation was for the resident's pain to be controlled in collaboration with the facility and Hospice.<br><br>An interview on 05/04/18 at 7:46 PM with the facility Medical Director revealed the resident commonly winced when examined but stated it was his hope since it was the premise of Hospice to keep residents comfortable they would be able to do that for Resident #6. | F 697 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2) | F 761 | | 5/31/18 |

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| F 761 | Continued From page 45<br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to remove expired medication and loose pills from 2 of 2 observed medication carts (A medication cart and Split medication cart).<br><br>The findings included:<br><br>1 a. An observation was made of the A medication cart on 05/03/18 at 11:21 AM along with Nurse #2. The following medications were found on the medication cart and were available for use: 20 pills of Zofran 4 milligrams (mg) | F 761 | F 761 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Corrective action has been accomplished for the alleged deficient practice in regards to 20 pills of Zofran, 21 pills of Meclizine, 30 pills of Loperamide, and Omeprazole along with the loose pills. Nurse #2 and Nurse #3 discarded the medications according to appropriate | |

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(anti-nausea medication) that expired on 12/26/17 and was in the original package, 21 pills of meclizine 25 mg (anti-nausea medication) that expired 12/12/17 and was in the original package, and 30 pills of loperamide 2 mg (anti-diarrheal medication) that expired on 04/30/18 and was in the original package. In addition to the expired medications, the following loose pills were noted in the 2nd drawer of the medication cart: 1 orange round pill, 2 round white pills, 1 oblong white pill, 1 red oblong pill, and ½ yellow pill.

An interview was conducted with Nurse #2 on 05/03/18 at 11:35 AM. Nurse #2 stated that she checked the expiration date on each medication that she gave so she assumed the medications had been discontinued. She added she would have to research how the expired medications were still located on the medication cart and available for use. Nurse #2 was not aware what the loose pills were and stated she did not know how or why the loose pills were located in her medication cart but stated she would properly dispose of them.

b. An observation was made of the Split medication cart on 05/03/18 at 5:32 PM along with Nurse #3. The observation revealed 1 pill of omeprazole (used to treat stomach ulcers) 20 mg that expired 03/31/17 that remained in the original package and on the medication cart available for use. In addition to the expired medication there was a red round pill noted to be loose in the top drawer of the medication cart.

An interview was conducted with Nurse #3 on 05/03/18 at 5:47 PM. Nurse #3 stated that the administrative nurses had just gone through the Split medication cart looking for expired

facility and medication disposal policy on 5/3/18.
2. The Director of Nursing/Unit Managers/Supervisors completed an audit on 5/04/18 of all medication carts to validate that there were no expired medications remaining in the carts. Any found were disposed of per facility policy.
" The procedure for implementing the acceptable plan of correction for specific deficiency cited:
1. The Director of Nursing/Unit Managers/Supervisors initiated in service education for the licensed nurses on 5/23/18 regarding removal of expired medications.
2. The in service education will be provided during orientation for newly hired licensed nurses.
" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:
1. The Director of Nursing/Unit Managers/Supervisors will audit all medication carts 3 times a week for 4 weeks then weekly for 3 months, to validate that all expired medications are removed.
2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.

" The title of the person responsible for

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| F 761 | Continued From page 47<br>medication and must have over looked the expired medication. She added that she was not sure what the loose red pill was but she would dispose of the medication.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/04/18 at 6:04 PM. The DON stated that the 3rd shift nurses were responsible for going through the medication carts each night looking for expired and loose medication. She added that the 3rd shift nurses also tracked the discharges and removed their medication from the medication cart and returned them to the pharmacy per the facility policy. The DON stated that she expected the 3rd shift nurses to remove any expired or loose medication and return them to the pharmacy or destroy them appropriately. She added that a month ago she had removed everything from the A medication cart and cleaned the cart so the loose pills were new since that time. | F 761 | implementing the acceptable plan of correction:<br>1. The Administrator | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident | F 842 | | 5/31/18 |

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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-
(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-

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| F 842 | Continued From page 49<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, family, and staff interviews the facility failed to maintain an accurate medical record by not documenting a skin tear in the medical record for 1 of 2 residents sampled for non-pressure wounds (Resident #67).<br><br>The findings included:<br><br>Resident #67 was initially admitted to the facility on 08/14/12 and was most recently readmitted to the facility on 04/21/18. Her diagnoses included urinary tract infection, myocardial infarction, chest pain, weakness, and hypertension.<br><br>Review of the most recent comprehensive Minimum Data Set (MDS) dated 04/27/18 revealed that Resident #67 was cognitively intact and required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. Skin tears were checked on the MDS.<br><br>An interview was conducted with Resident #67 and her family on 04/30/18 at 11:18 AM. Resident #67's family member stated that Resident #67 had received a skin tear to her right lower leg in | F 842 | F 842 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. Resident #67 incident of receiving a skin tear to her right lower leg while being transferred from the shower chair to her wheelchair in the shower room on 3/20/18 has been entered into her medical record as a late entry on 5/22/18.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. The Director of Nursing/Unit Managers completed an audit on 5/25/18 on all incidents/accidents from 3/20/18 to 5/25/18 to ensure proper documentation of any incidents/accidents are in the resident medical record. Any variants identified were addressed per facility policy.<br>2. The Director of Nursing/Unit managers initiated in services on current nursing staff on properly documenting all incidents/accidents into the resident | |

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| F 842 | Continued From page 50<br>shower room on 03/20/18 and the wound doctor was treating it. Resident #67 confirmed the skin tear and the information provided by her family member.<br><br>Review of Resident #67's medical record revealed no documentation of a skin tear that occurred on 03/20/18 in the shower room to her right lower leg.<br><br>Review of an incident report dated 03/21/18 that stated, "privileged and confidential-not part of the medical record" indicated that Resident #67 had received a skin tear to her right lower leg while transferring after completing her shower. The nurse cleaned and dressed the wound and the form was completed by the Director of Nursing (DON).<br><br>An interview was conducted with the DON on 05/04/18 at 5:33 PM. The DON stated that the hall nurses filled out a paper incident form and then she entered them all into the electronic risk management system. She added Nurse #1 completed the incident report on 03/20/18 and then she had completed the electronic report. The DON stated that she expected Nurse #1 to document the incident in the electronic medical record in addition to filling out the paper report. The DON also indicated she had not noticed that the event was not documented in Resident #67's medical record. She also stated that she had put the wrong date on the incident report that it happened on 03/20/18 and not on 03/21/18.<br><br>An attempt to speak to Nurse #1 on 05/04/18 at 5:04 PM was unsuccessful.<br><br>An interview was conducted with Nursing | F 842 | medical record on 5/23/18.<br>3. The in service education will be provided during orientation for newly nursing staff.<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. The Director of Nursing/Unit Managers will review risk management reports during the clinical morning meeting to ensure proper nursing note documentation for all incidents/accidents 5 times a week x 4 weeks, then 3 x times a week for 4 weeks, then 1 x a week for a month.<br>2. The Director of Nursing will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting monthly x 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |

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| F 842 | Continued From page 51<br>Assistant (NA) #3 on 05/05/18 at 11:58 AM. NA #3 confirmed that she was caring for Resident #67 on 03/20/18 and had taken her to the shower that day. She explained that Resident #67 did obtain a skin tear to her right lower leg while transferring that day and she had reported the incident to Nurse #1. She added that Nurse #1 came to the shower room and cleaned and dressed the skin tear before she returned Resident #67 to her room. | F 842 | | |
| F 865 SS=E | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>CFR(s): 483.75(a)(2)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the | F 865 | F 865 Deficiency corrected<br><br>" The Plan for correcting the specific deficiency:<br>1. In regards to F584: The indention in | 5/31/18 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 865 | Continued From page 52<br>recertification survey of 03/23/17. This was for one recited deficiency which was originally cited during the annual recertification and complaint survey of 04/20/15, was cited again during the annual recertification survey of 02/12/16, was subsequently cited again during the recertification and complaint survey of 03/23/17 and was recited again on the current recertification and complaint survey of 05/05/18. This repeat deficiency was in the area of housekeeping and maintenance services. A second deficiency was originally cited during the recertification and complaint survey of 03/23/17 and was cited again during the current recertification and complaint survey of 05/05/18. This repeat deficiency was in the area of labeling and medication storage. The continued failure of the facility during four federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag is cross referred to:<br><br>1. F 584 Safe, Clean, Comfortable and Homelike Environment: Based on observations and staff interviews the facility failed to repair a cracked indention in the floor (outside of room #104) and clean a yellowish/brownish smear on the wall of 1 room (Room 105) on 1 of 2 rehab halls.<br><br>During the recertification and complaint survey of April 20, 2015 the facility was cited for failure to repair a hole in the wall, a hole in a resident bathroom door, clean privacy curtains in 2 resident rooms and failed to clean a sit to stand lift for providing maintenance and housekeeping services. | F 865 | the floor outside room #104 was repaired on 5/4/18. The indented tile was remove and a new tile was placed at the spot presenting a smooth even surface.<br>2. In regards to F584: The smear of unknown origin in resident room #105 was cleaned off on 5/4/18.<br>3. In regards to F761: Corrective action has been accomplished for the alleged deficient practice in regards to 20 pills of Zofran, 21 pills of Meclizine, 30 pills of Loperamide, and Omeprazole along with the loose pills. Nurse #2 and Nurse #3 discarded the medications according to appropriate facility and medication disposal policy on 5/3/18.<br>" The procedure for implementing the acceptable plan of correction for specific deficiency cited:<br>1. In regards to F584: The Administrator and Director of Maintenances conducted an audit on 5/4/18 of current facility residents rooms and facility common areas, to identify indentations in the tile floor that could present a safety hazard for residents or staff. No other issues were identified.<br>2. In regards to F584: The Administrator and Housekeeping Manager conducted an audit of resident rooms on 5/4/18 to identify marks on walls that need to be addressed. Cleaning/painting were initiated where indicated.<br>3. In regards to F584: The Administrator, Director of Maintenance and Housekeeping manager provided in service education for the nursing staff, maintenance staff and housekeeping staff beginning on 5/8/18, regarding reporting | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345133 | A. BUILDING _____ B. WING _____ | C 05/05/2018 |

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| F 865 | Continued From page 53<br>During the recertification survey of February 12, 2016 the facility was again cited for failure to repair resident room doors and/or bathroom doors with broken and splintered laminate and wood for 9 of 61 resident rooms. (Resident room #112, #122, #127, #132, #136, #138, #140, #143 and #147).<br><br>During the recertification survey of March 3, 2017 the facility was cited for failure to label personal care equipment which included a bath basin in the bathroom of room #107, failed to store a bed pan in a plastic bag or label it in the bathroom of room #147 and failed to repair a leaking toilet with brown stains inside the toilet bowl in the bathroom of room #111 in 3 of 61 resident rooms.<br><br>2. F 761 Label and store drugs and biologicals: Based on observations and staff interviews the facility failed to remove expired medication and loose pills from 2 of 2 observed medication carts (A medication cart and Split medication cart).<br><br>During the recertification and complaint survey of March 23, 2017 the facility was cited for failure to discard an opened Novolog insulin FlexPen that was available for use in 1 of 4 medication carts.<br><br>During an interview on 05/04/18 at 7:46 PM the Administrator explained the Quality Assessment and Assurance committee meetings were conducted on a monthly basis which included the Administrator, Medical Director, Director of Nursing and various Department Managers. He further explained the Pharmacist attended the meetings on a quarterly basis. He stated deficiencies identified during the current recertification survey would be discussed with ongoing monitoring as the committee determined. | F 865 | in Point Click Care maintenance repair request system (TELS) needed repairs to proper employees to enable timely repair.<br>4. In service education will be provided during orientation for newly hired staff.<br>5. In regards to F761: The Director of Nursing/Unit Managers/Supervisors initiated in service education for the licensed nurses on 5/23/18 regarding removal of expired medications.<br>6. The in service education will be provided during orientation for newly licensed nursing staff.<br>" The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>1. In regards to F584: The Administrator, Director of Maintenance and Housekeeping manager will make weekly rounds together /for 4 weeks and then monthly for 3 months to identify and institute any repairs or additional cleaning needed according to facility protocol.<br>2. In regards to F761: The Director of Nursing/Unit Managers/Supervisors initiated in service education for the licensed nurses on 5/23/18 regarding removal of expired medications. The Director of Nursing/Unit Managers/Supervisors will audit all medication carts 3 times a week for 4 weeks then weekly for 3 months, to validate that all expired medications are removed.<br>3. In regards to F584 and F761: The Administrator and Interdisciplinary team which includes at least the Medical | |

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| F 865 | Continued From page 54<br>He stated the environmental deficiencies were due in part to a fifty year old building that was difficult to maintain but he expected for staff to keep the facility clean and maintained. He explained it was an ongoing process to prevent repeat deficiencies and they would put procedures to monitor environmental and housekeeping issues and they would put a procedure in place to check storage of medications. He stated the deficiency for medication storage on the last recertification survey was for a different concern and they would have to put plans in place to prevent further deficiencies. He explained he would have to read the final survey report before he could determine the plans they would put into place but they would be developed to prevent the deficiencies from reoccurring in the future. | F 865 | Director, DON, MDS coordinators, Maintenance director, Social worker, dietary manager, Pharmacist and nursing assistants to identify areas of improvement through daily rounds, observations, grievances, quality measures and develop plans for improvement and ongoing monitoring for continued compliance and improvement.<br>4. In regards to F584 and F761: The Administrator and Director of Nursing will analyze audits/reviews/reports for patterns/trends and report findings in the Quality Assurance committee meeting monthly for 3 months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified.<br>" The title of the person responsible for implementing the acceptable plan of correction:<br>1. The Administrator | |