STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345002	A. BUILDING ______ B. WING ______	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS POINTE REHABILITATION CENTER	**2006 SOUTH 16TH STREET** **WILMINGTON, NC 28401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		6/13/18

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

Electronically Signed — 06/08/2018

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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to ensure a resident was assisted to the bathroom as requested causing the resident to experience incontinence and a lack of dignity for 1 of 1 residents (Resident # 15). Findings included: Review of the quarterly Minimum Data Set (MDS) dated 03/16/18 revealed Resident #15 was admitted to the facility on 10/09/17 and had diagnoses of hypertension, diabetes, and depression. Resident #15 was cognitively intact and needed the limited assistance of one person for transfers and toilet use. Resident #15 was occasionally incontinent of bladder. Review of the information provided to the nursing staff that directed the care of each resident (Care Guide) revealed that on 05/21/18 Resident #15 needed the limited assistance of one person for toileting needs and needed the limited assistance of one person for transfers. In an observation on 05/21/18 at 8:40 AM the call light above the door of Resident #15's room was lit up. A male staff member walked past the room without acknowledging the light. Two female staff members were at the end of the hallway speaking together. The call light was lit up on the panel at the nurse's station and the alarm was sounding. No staff members were at the nurse's station. Resident #15 was sitting on the bed with her legs thrown over the side of the bed. The head of the bed was elevated and she was leaning against the mattress in an awkward appearing position.	F 550	Preparation and execution of this plan of correction, does not constitute admission or agreement of the alleged facts set fourth in this statement of deficiency. The plan of correction is prepared and or executed due to Federal and State requirements. F550 1. Resident #15 was provided with incontinent care as well as a shower on 5/21/2018. There were no negative outcomes as a result of this deficiency 2. Root cause: The staff failed to assist the resident to the restroom in timely manner due to her transfer status not being clear amongst staff members. The time that elapsed during the validation of transfer status caused the resident to have an episode of incontinence. An audit was conducted on other residents residing in the facility on 5-22-2018 through 5-25-2018 and no residents were found to be soiled. 3. The DON/designee will conduct re-education with nursing staff by 6/13/2018 on providing timely incontinence care and accessing current resident transfer status. Audits will be conducted 3 times a week on providing timely incontinence care for 12 weeks. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee	

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F 550	Continued From page 2 Resident #15 was wearing a brief. She indicated she needed to use the bathroom but could not get out of the bed on her own to get to the bathroom. At 8:45 AM the MDS Nurse entered Resident #15's room and was told by the resident that she needed to use the bathroom. At 8:50 AM the MDS Nurse left the room after informing Resident #15 that she was going to check on how the resident was transferred. At 8:53 AM the MDS Nurse came back to the room with some linens. At 8:59 AM the MDS Nurse left the room after explaining to Resident #15 that a resident from the room next door was now in the adjoining bathroom and that she (Resident #15) would need to wait to use the bathroom. The MDS Nurse informed Resident #15 the aide that was helping the resident next door had been told to let staff know when the bathroom was available for Resident #15's use. At 9:06 AM the Speech Therapist (ST) came to Resident #15's room. She indicated Resident #15 had a mild stroke approximately five days prior but was recovering quickly. At 9:10 AM the Rehabilitation Aide (RA) came to Resident #15's room. She indicated she was not assigned to Resident #15 that day but had been told by a staff member (she was unable to remember who) to see if the resident needed assistance with transferring to the bathroom. The bathroom became available for Resident #15 to use. At 9:11 AM the RA left Resident #15's room stating she would find out how the resident transferred. At 9:14 AM the Rehabilitation Director came into Resident #15's room. She informed Resident #15 that the Physical Therapist (PT) (on 05/16/18) had changed her transfer status to a two person mechanical lift transfer following her recent stroke and that the lift could not be used to take her into the bathroom in her room because the mechanical lift	F 550	meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 550	Continued From page 3 would not fit in the bathroom. The Rehabilitation Director indicated that Resident #15 would probably feel more comfortable with the PT she was familiar with and he was sent for. Resident #15 indicated that she had not been transferred to the bathroom using the mechanical lift and did not want to use it because she was afraid it would injure her leg. At 9:20 AM Resident #15 indicated that she had already wet herself because she could no longer hold it. She stated at first it bothered her when she wet herself but now she was used to it because it always took staff a long time to help her and she was used to it. At 9:28 AM the PT came to Resident #15's room with a walker and she was assisted to sit on the edge of the bed in preparation for transfer into a wheelchair. The PT indicated that the nursing staff was supposed to use the mechanical lift for transfers and only the therapists could transfer Resident #15 using a walker. Resident #15 was still requesting to use the bathroom so the PT decided to transfer her into the wheelchair and take her to the shower room where she could be transferred to a shower chair and placed over the toilet. Resident #15 was assisted to stand in preparation for transfer to the wheelchair. The back of her gown was noted to be saturated with urine. The brief that Resident #15 wore appeared to be saturated with urine. There was a fabric lined, plastic backed, incontinence pad over a folded in quarters bath blanket on top of the bottom sheet. The bath blanket and incontinence pad were both saturated with urine. The bottom sheet was wet from the shoulder area to the mid-thigh area. The Rehabilitation Director removed the saturated linens and rivulets of urine were noted on the mattress. A strong smell of urine was noted at the time the linens were exposed. The Rehabilitation Director offered	F 550		

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F 550	Continued From page 4 Resident #15 a shower and stated it was not acceptable that Resident #15 was found in that condition. At 9:36 AM Resident #15 was taken to the shower room where she required the assistance of three staff members to stand. At 9:39 AM the saturated brief was removed and Resident #15 was placed in a shower chair over the toilet to use the bathroom. When the brief was removed Resident #15's buttocks were noted to be red but there was no breakdown. Resident #15 stated her buttocks were red because she had laid in urine for so long. Throughout the continuous observation there had never been any offer of a bedpan or to check Resident #15's brief to see if incontinence care could be provided while her transfer status was being established. In an interview on 05/21/18 at 10:28 AM Nursing Assistant (NA) #1 indicated she had checked Resident #15 at approximately 7:30 AM by looking at the front of the brief for a color change on the moisture indicator line. There was no change in color to indicate that Resident #15 had been incontinent of urine. She indicated she fed Resident #15's roommate her breakfast and told Resident #15 she would be back to provide care. NA #1 stated Resident #15 did not tell her she was wet when she served her breakfast. She indicated she had used the mechanical lift to get Resident #15 out of bed on 05/19/18. In an interview on 05/21/18 at approximately 10:35 AM the Director of Nursing (DON) stated the care guides for each resident were only in the computer. She stated the nursing staff all had access to the information and should be going into the computer to see how to care for the residents.	F 550		

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F 550	Continued From page 5	F 550		

In an interview on 05/22/18 at 9:51 AM the Occupational Therapist (OT) stated the nursing staff was supposed to use a mechanical lift to transfer Resident #15.

In an interview on 05/24/18 at 5:18 PM the MDS Nurse stated that a lot of things had been discussed about Resident #15 in clinical meetings. She indicated she remembered a discussion that Resident #15 may or may not be appropriate for therapy but did not remember any discussion about the use of a mechanical lift so was not aware Resident #15 needed one for transfers. She indicated she and the MDS Coordinator were responsible for updating the care guides but since a significant change MDS was in process Resident #15's care plans and care guide had not yet been updated.

In an interview on 05/25/18 at 10:05 AM Nurse #4 stated the PT had informed her on 05/16/18 that Resident #15 needed a mechanical lift for transfers. She indicated there was a big problem with communication in the facility. Nurse #4 stated she did not update the care guide as that was up to the MDS Nurse to do.

In an interview on 05/25/18 at 11:45 AM the PT stated he had informed Nurse #4 on 05/16/18 that Resident #15 required a mechanical lift for transfers by nursing staff.

In an interview on 05/25/18 at 12:15 PM the Administrator stated the delay in transfer and the resident being saturated was not intentional. She indicated the facility was trying to do what was best for Resident #15 to keep her safe. She stated Resident #15 should not have had to wait that long to be taken to the bathroom and that

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F 550	Continued From page 6 she expected current transfer information to be readily available to the staff. In an interview on 05/25/18 at 2:05 PM the DON stated she expected the correct transfer information to be on the care guide and for staff to know how to access the information The DON stated she expected residents to be treated with dignity and that it should not have taken so long to figure out how Resident #15 transferred so she could be taken to the bathroom. She indicated a resident's mental health should be maintained and no resident should be made to feel that they were not being cared for.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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. (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. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		6/13/18

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F 584	Continued From page 7 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to maintain a clean living environment for 2 of 12 resident areas observed that had visible feces dried on the floor in a resident's room (#20B) and on the wall in the bathroom between rooms (#4 and #6). Findings included: During the initial tour of the facility on 05/20/18 at 11:00 AM dirty, used latex gloves and two quarter size areas of dried feces were observed on the floor beside a resident's bed in Room 20B. In an interview with Nurse #7 on 05/20/18 at 11:15 AM she stated that she was the nurse assigned to Room 20B. She reported that she had been employed at the facility for one week. The feces was witnessed by herself and the	F 584	F584 1. Room 20 and the bathroom between room 4 and 6 were cleaned appropriately upon notification during survey. There were no negative outcomes as a result of this observation. 2. Root Cause: The staff denied seeing any feces on the floor in room 20 and in in the bathroom between room 4 and 6. The housekeeping staff and nursing staff are aware of the cleaning techniques for body fluids. An audit was conducted by the facility housekeeping manager following notification, there were no similar findings. 3. The Housekeeping Manager/Designee will conduct re-education to staff regarding maintaining a sanitary environment by 6/11/2018. Staff will also be educated on checking rooms and	

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F 584	Continued From page 8 Housekeeping Director. Nurse #7 reported that she would use bleach wipes to clean up the dried feces and then ask housekeeping to disinfect the floor. The Housekeeping Manager stated that it was the responsibility of nursing to clean up the initial spillage and then housekeeping's responsibility was to disinfect the area. He stated that he would not have expected feces to be dried on the floor of a resident's room at 11:00 AM. He said it should have been seen and cleaned on the first rounds after breakfast by housekeeping. A follow up observation at 1:30 PM revealed that the dried stool had been cleaned from the floor and the trash removed. An additional observation of dried feces splattered on the wall in the bathroom between resident rooms #4 and #6 was made on 05/20/18 on initial tour. The feces was again observed on the wall at 2:30 PM on 05/23/18 (3 days later). It was shown to the Housekeeping Director on 05/23/18 who stated it should have been cleaned up earlier either by nursing or housekeeping. He summoned a housekeeper who cleaned the feces off the wall. Record review of the contracted housekeeping company policy revealed: "Any equipment or furniture that is contaminated with visibly large quantities of blood or other bodily fluids will be referred to nursing personnel of the client facility for decontamination and will not be handled by employees of (the housekeeping company). Employees are only to clean previously decontaminated areas or small areas requiring clean up (i.e. drips of blood or urine)." In an interview with the Housekeeping Director on 5/23/18 at 2:34 PM he stated that housekeeping	F 584	bathroom areas for cleanliness by 6/11/2018. Audits will be conducted 3 times a week for 12 weeks to ensure a sanitary environment is maintained on resident care areas to include bathroom. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 584	Continued From page 9 staff arrived at 8:00 AM each day and started cleaning the common areas because breakfast trays were still on the hallways. After the trays came off the floor he said staff began room rounds that included sweeping, emptying trash, and checking soaps and paper towel needs. The next step included going back through the rooms and wiping down horizontal surfaces, sweeping behind furniture, cleaning bathrooms, and mopping floors. He said the rooms were revisited after lunch for additional cleaning if needed. He stated that this was the 5 step method of cleaning. He said the 7 step method of cleaning was also used when rooms where scheduled to be deep cleaned. In an interview with CNA #12 on 05/23/18 at 3:05 she stated that if she saw feces on the floor she would have cleaned it up with a towel and water and had called housekeeping to disinfect the area. She said the aides had to remove it before housekeeping would disinfect the area. Interview with the Director of Nursing on 05/23/18 at 3:15 PM she said it was her expectation that as soon as feces was seen on the floor it would be cleaned up. She said the nursing staff was to clean the area first with a solution kept in the housekeeping closet and then housekeeping was to disinfect the area. She said if there were no housekeeping staff available that there was a supply room with disinfectant, a mop and a mop bucket to enable nursing to completely clean the area entirely.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		6/13/18

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F 600	Continued From page 10 Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to have the correct transfer information accessible to staff causing a 59 minute delay in toileting for 1 of 1 residents (Resident # 15). Findings included: Review of the quarterly Minimum Data Set (MDS) dated 03/16/18 revealed Resident #15 was admitted to the facility on 10/09/17 and had diagnoses of hypertension, diabetes, and depression. Resident #15 was cognitively intact and needed the limited assistance of one person for transfers and toilet use. Review of the 05/01/18-05/20/18 Physical Therapy and Occupational Therapy notes revealed no mention that nursing was to use a mechanical lift to transfer Resident #15. Review of the information provided to the nursing staff that directed the care of each resident (Care Guide) revealed that on 05/21/18 Resident #15 needed the limited assistance of one person for	F 600	F600 1. Resident #15 was provided with incontinent care as well as a shower on 5/21/2018. There were no negative outcomes as a result of this deficiency 2. Root cause: The facility staff did not communicate effectively on the change in the resident’s transfer status so that her plan of care could be updated. The time that elapsed during verification of residents transfer status caused the resident to have an episode of incontinence. The transfer status was updated while trying to conversation to transfer resulted in an incontinent episode. An audit was conducted on all other residents in the facility to ensure transfer status was correct, there were no similar findings 3. The NHA/Designee will conduct re-education with nursing staff by 6/11/2018 regarding the facility policy on abuse prohibition. The nursing staff will be	

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F 600	Continued From page 11 toileting needs and needed the limited assistance of one person for transfers. In an observation on 05/21/18 at 8:40 AM the call light above the door of Resident #15's room was lit up. A male staff member walked past the room without acknowledging the light. Two female staff members were at the end of the hallway speaking together. The call light was lit up on the panel at the nurse's station and the alarm was sounding. No staff members were at the nurse's station. Resident #15 was sitting on the bed with her legs thrown over the side of the bed. The head of the bed was elevated and she was leaning against the mattress in an awkward appearing position. Resident #15 was wearing a brief. She indicated she needed to use the bathroom but could not get out of the bed on her own to get to the bathroom. At 8:45 AM the MDS Nurse, who had been speaking with the staff member at the end of the hall, entered Resident #15's room. She had a short conversation with Resident #15 and was told by the resident that she needed to use the bathroom. At 8:50 AM the MDS Nurse left the room after informing Resident #15 that she was going to check on how the resident was transferred. At 8:53 AM the MDS Nurse came back to the room with some linens and had another discussion with Resident #15. At 8:59 AM the MDS Nurse left the room after explaining to Resident #15 that a resident from the room next door was now in the adjoining bathroom receiving care and that she would need to wait to use the bathroom. The MDS Nurse informed Resident #15 that she wanted to provide care at the same time she was in the bathroom and that the aide had been told to let staff know when the bathroom was available for Resident #15's use. At 9:06 AM the Speech Therapist (ST) came to	F 600	educated on how to access the kardex for transfer status by 6/11/2018. The MDS was educated also on updating the plan of care for any changes. Audits will be conducted 3 times a week on providing timely incontinence care and that the transfer status in followed as outlined in the plan of care for 12 weeks. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 600	Continued From page 12 Resident #15's room. She indicated Resident #15 had a mild stroke approximately five days prior but was recovering quickly. At 9:10 AM the Rehabilitation Aide (RA) came to Resident #15's room. She indicated she was not assigned to Resident #15 that day but had been told by a staff member (she was unable to remember who) to see if the resident needed assistance with transferring to the bathroom. The resident who was in the bathroom had been taken back to her room and the bathroom was available for Resident #15's use. At 9:11 AM the RA left Resident #15's room stating she would find out how the resident transferred. At 9:14 AM the Rehabilitation Director came into Resident #15's room. She informed Resident #15 that the Physical Therapist (PT) had changed her transfer status to a two person mechanical lift transfer following her recent stroke and that the lift could not be used to take her into the bathroom in her room due to its size. The Rehabilitation Director indicated that Resident #15 would probably feel more comfortable with the PT she was familiar with and he was sent for. At 9:20 AM Resident #15 indicated that she had already wet herself because she could no longer hold it. She stated at first it bothered her when she wet herself but now she was used to it because it always took staff a long time to help her and she was used to it. At 9:28 AM the PT came to Resident #15's room with a walker and she was assisted to sit on the edge of the bed in preparation for transfer into a wheelchair. The PT indicated that the nursing staff was supposed to use the mechanical lift for transfers and only the therapists could transfer Resident #15 using a walker. Resident #15 was still requesting to use the bathroom so the PT decided to transfer her into the wheelchair and take her to the shower room where she could be	F 600		

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F 600	Continued From page 13 transferred to a shower chair and placed over the toilet. Resident #15 was assisted to stand in preparation for transfer to the wheelchair. The back of her gown was noted to be saturated with urine. The brief that Resident #15 wore appeared to be saturated with urine. There was a fabric lined, plastic backed, incontinence pad over a folded in quarters bath blanket on top of the bottom sheet. The bath blanket and incontinence pad were both saturated with urine. The bottom sheet was wet from the shoulder area to the mid-thigh area. The Rehabilitation Director removed the saturated linens and rivulets of urine were noted on the mattress. A strong smell of urine was noted at the time the linens were exposed. The Rehabilitation Director offered Resident #15 a shower and stated it was not acceptable that Resident #15 was found in that condition. At 9:36 AM Resident #15 was taken to the shower room where she required the assistance of three staff members to stand. At 9:39 AM the saturated brief was removed and Resident #15 was placed in a shower chair over the toilet to use the bathroom. When the brief was removed Resident #15's buttocks were noted to be red but there was no breakdown. Resident #15 stated her buttocks were red because she had laid in urine for so long. Throughout the continuous observation there had never been any offer of a bedpan or to check Resident #15's brief to see if incontinence care could be provided while her transfer status was being established. In an interview on 05/21/18 at 10:28 AM Nursing Assistant (NA) #1 indicated she had checked Resident #15 at approximately 7:30 AM by looking at the front of the brief for a color change on the moisture indicator line. There was no change in color to indicate that Resident #15 had	F 600		

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been incontinent of urine. She indicated she fed Resident #15's roommate her breakfast and told Resident #15 she would be back to provide care. NA #1 stated Resident #15 did not tell her she was wet when she served her breakfast.

In an interview on 05/21/18 at approximately 10:35 AM the Director of Nursing (DON) stated the care guides for each resident were only in the computer. She indicated there were no printed copies in resident closets or in binders at the nurse's desks. She stated the nursing staff all had access to the information and should be going into the computer to see how to care for the residents.

In an interview on 05/22/18 at 9:51 AM the Occupational Therapist (OT) stated only the therapists could transfer Resident #15 out of bed using a walker. She indicated the nursing staff was supposed to use a mechanical lift for transfers.

In an interview on 05/22/18 at 10:43 AM the Rehabilitation Director stated the RA had come to ask the PT how to transfer Resident #15. She indicated the PT was working with another resident so she came to Resident #15's room. She indicated Resident #15 had experienced a stroke recently and that a significant change MDS was underway. She stated a physical therapy evaluation was done and it was decided a mechanical lift should be used for transfers. The Rehabilitation Director stated the change to a mechanical lift was discussed in a clinical meeting which the MDS Nurse attended. She indicated that the change to a mechanical lift for transfers by the nursing staff had not been updated to the care guide.

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F 600	Continued From page 15 In an interview on 05/22/18 at 10:53 AM the facility Nurse Consultant stated the change in Resident #15's transfer status was discussed in a clinical meeting that the MDS Nurse attended. She stated the MDS Nurse should have updated the care guide to show that a mechanical lift was now needed for transfers. In an interview on 05/22/18 at 2:30 PM NA #2 stated the only way she knew how to take care of a resident was if she already knew them or she could ask the nurse. She indicated there were no care guides to look at. NA #2 stated when she recorded a resident's activities of daily living she would put down how she transferred a resident but there was nothing that told her how the resident should be transferred. In an interview on 05/22/18 at 3:03 PM NA #3 stated she could find the information on how residents were transferred in the electronic record. In an interview on 05/23/18 at 6:00 AM NA #4 stated she was an agency aide and this was her third time at the facility. She stated the care guides for residents hung inside their closets. In an interview on 05/23/18 at 6:05 AM NA #5 stated she was an agency aide but worked at the facility about three times each week. She indicated there was a book at the nurse's desk with the information on how to care for each resident or she could ask the nurse. In an interview on 05/23/18 at 6:20 AM NA #6 stated she was a staff aide and had worked in the facility for a few months. She indicated if she did	F 600		

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not know how to care for a resident she would ask the nurse. She stated that before she was in-serviced yesterday she did not know the information on how to care for residents was in the computer.

In an interview on 05/23/18 at 6:42 AM NA #7 stated she documented in the computer and could go there to find the information on how to transfer a resident.

In an interview on 05/24/18 at 12:50 PM the Rehabilitation Director stated when a therapist documented a resident needed maximum assistance it meant something different to each therapist. She indicated that in Resident #15's case the PT meant that the nursing staff needed to use a mechanical lift for transfers. She indicated the need for a mechanical lift was discussed in a clinical meeting and the MDS Nurse was at the meeting. The Rehabilitation Director stated the care guide should have been updated with Resident #15's new transfer needs. She indicated she felt there was a problem with verbal communication between disciplines.

In an interview on 05/24/18 at 3:14 PM Nurse #3 stated that until two days ago she did not know that Resident #15 needed a mechanical lift for transfers by the nursing staff. She indicated that if she had been asked by an aide how to transfer Resident #15 she would have told them that two people were necessary but not that a mechanical lift was needed.

In an interview on 05/24/18 at 5:18 PM the MDS Nurse stated that a lot of things had been discussed about Resident #15 in clinical meetings. She indicated she remembered a

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discussion that Resident #15 may or may not be appropriate for therapy but did not remember any discussion about the use of a mechanical lift so was not aware Resident #15 needed one for transfers. She indicated she and the MDS Coordinator were responsible for updating the care guides but since a significant change MDS was in process Resident #15's care plans and care guide had not yet been updated.

In an interview on 05/25/18 at 10:05 AM Nurse #4 stated the PT had informed her on 05/16/18 that Resident #15 needed a mechanical lift for transfers. She indicated she would have told the aide who should have passed the information on in report. She indicated she thought she would have put the information on the shift report and told the oncoming nurse but was not sure if she had done that. She indicated there was a big problem with communication in the facility. Nurse #4 stated she did not update the care guide as that was up to the MDS Nurse to do.

In an interview on 05/25/18 at 11:45 AM the PT stated he had informed Nurse #4 on 05/16/18 that Resident #15 required a mechanical lift for transfers by nursing staff.

In an interview on 05/25/18 at 12:15 PM the Administrator stated the delay in transfer and the resident being saturated was not intentional. She indicated the facility was trying to do what was best for Resident #15 to keep her safe. She stated Resident #15 should not have had to wait that long for transfer and that she expected current transfer information to be readily available to the staff.

In an interview on 05/25/18 at 1:10 PM NA #8

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F 600	Continued From page 18 stated she had found Resident #15 saturated before when she took over her assignment. She indicated she had informed the hall nurse and the DON. NA #8 stated there was a lack of communication in the facility. In an interview on 05/25/18 at 2:05 PM the DON stated she expected the correct transfer information to be on the care guide and for staff to know how to access the information. She indicated she expected the care guide to be updated as necessary and for there to be better communication between therapy and nursing. The DON stated she expected residents to be treated with dignity and that it should not have taken so long to figure out how Resident #15 transferred. She indicated a resident's mental health should be maintained and no resident should be made to feel that they were not being cared for. She stated that no resident should experience neglect and that the facility was trying to do what was safest for Resident #15.	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess a resident (Resident #56) who had a change in condition and was admitted to the hospital for 1 of 1 residents observed.	F 658	F658 1. Resident #56 was assessed by Nurse #4 and findings were provided to the mid-level provider a order was obtained to transfer resident #56 to the emergency room for further evaluation 5/22/2018.	6/13/18

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F 658	Continued From page 19 Findings included: Resident #56 was admitted to the facility on 03/20/18. Diagnoses included, in part, dementia, insomnia, A-fib, anxiety, chronic cystitis without hematuria (blood in the urine), muscle weakness and difficulty walking. The Minimum Data Set (MDS) 30-day quarterly assessment revealed Resident #56 was cognitively aware. There were no moods or behavior indicated. Resident #56 required limited assistance with one staff assist with bed mobility, transfers, eating and toileting, supervision with one staff assist with locomotion on/off unit, extensive assist with one staff assist with dressing and personal hygiene. Resident #56 was always continent of bowel and bladder. An interview with Resident #56 on 05/20/18 at 2:30 PM revealed an alert and pleasant resident. Resident #56 was propelling herself in the wheelchair. An observation of Resident #56 on 05/21/18 at 9:15 AM revealed the resident was out of bed, dressed and propelling herself in her wheelchair. An observation of Resident #56 on 05/21/18 at 12:45 PM revealed the resident was out of bed and propelling her- self in her wheelchair. An interview with Resident #56 on 05/21/18 at 12:45 PM was conducted. Resident #56 stated she was doing fine and had breakfast and lunch. An observation of Resident #56 on 05/22/18 at 9:00 am revealed the resident was lying in bed and appeared to be sleeping. The resident was	F 658	2. Root Cause: Nurse #4 had provided care to resident #56 during the morning and was going to assess the resident after her afternoon medication pass. The nurse reports that she should have assessed the resident sooner. Assessment were completed by facility RN's on 5/24/2018 on current residents, there was no similar findings noted. 3. Nurse #4 was educated on 5/22/2018 on timely assessment and notification the MD/RP on change of condition by the DON. The DON/Designee will conduct re-education on change in condition to licensed nurses by 6/11/18. Audits will be conducted 3 times a week for 12 weeks to ensure change in condition and timely assessments are completed appropriately. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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not dressed and there was no meal tray noted in her room.

An observation of Resident #56 on 05/22/18 at 10:00 am revealed the resident was lying in bed and appeared to be sleeping. The resident was not dressed.

An observation of Resident #56 on 05/22/18 at 11:00 am revealed the resident was lying in bed and appeared to be sleeping. The resident was not dressed and did not respond to verbal stimuli.

An interview was conducted with Nurse #4 on 05/22/18 at 11:07 AM. Nurse #4 revealed the resident stated she wasn ' t feeling well and she was sleepy. Nurse #4 stated the resident was confused earlier this morning when she came out of her room in her brief and wanted to go down the hall to use a bathroom. Nurse #4 reported she did not take her vital signs or do an assessment, but she and the nursing assistant (NA) assisted her back to bed. Nurse #4 stated it was a new behavior for the resident.

A review of a nursing progress note dated 05/22/18 indicted Resident #56 had a temperature of 102 degrees Fahrenheit with an irregular heart rate of 135 beats per minute and a distended abdomen. The note indicated Resident #56 was sent out to the emergency department for further evaluation.

An interview was conducted with Nurse #4 on 05/22/18 at 2:15 PM. Nurse #4 stated she asked the resident this morning if she was okay about 8:30 or 8:45 AM and the resident stated she did not feel well. Nurse #4 reported the resident got out of bed shortly after and took her morning

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F 658	Continued From page 21 medications and was noted to be confused as she was coming out of the room in her brief and attempting to wander. She stated this was not normal behavior. Nurse #4 stated she was going to assess her when she did her afternoon medication pass at 1:00 PM. Nurse #4 stated she should have assessed her when she presented with the new behavior and reported she did not feel well this morning. Nurse #4 stated she was sent to the Emergency Department around 12:00 pm on 05/22/18 with a fever and increased heart rate. An interview was conducted with NA #2 on 05/22/18 at 2:20 PM. NA #2 reported the resident did not eat breakfast and that was not her norm. She reported the resident usually ate in the dining room or her room and would get up and about every morning and was talkative. NA #2 stated when she went to assist her in the morning, the resident cussed at her. NA #2 stated the resident did not report she did not feel well, but her lying in bed, not eating her breakfast and cussing at her were not typical behaviors for her. NA #2 stated she reported it to Nurse #4. An interview with the facility physician on 05/23/18 at 11:30 AM revealed Resident #56 was admitted to the hospital with a Urinary Tract Infection (UTI). The physician revealed that although he felt the delay in treatment would not have changed the resident ' s outcome due to her history of chronic UTI ' s, his expectation of the nurse would have been to assess the resident when the resident indicated she did not feel well and exhibited a change in condition with her behavior. The physician then stated, "Clearly there was something going on and needed to be addressed."	F 658		

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F 658	Continued From page 22 An interview with the Nurse Practioner (NP) on 05/23/18 at 12:45 PM stated that she would have expected the nurse to assess the resident based on her new behavior. An interview with the Director of Nursing (DON) on 05/24/18 at 2:30 PM revealed her expectation of the nurse would have been to assess the resident when she presented with a change of condition with her behavior and complained of not feeling well.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews the facility failed to provide incontinence care for a resident dependent on staff for transfer and care for 1 of 1 residents (Resident #15). Findings included: Review of the quarterly Minimum Data Set (MDS) dated 03/16/18 revealed Resident #15 was admitted to the facility on 10/09/17 and had diagnoses of hypertension, diabetes, and depression. Resident #15 was cognitively intact and needed the limited assistance of one person for transfers and toilet use. Resident #15 was occasionally incontinent of bladder. Review of the information provided to the nursing staff that directed the care of each resident (Care	F 677	F677 1. Resident #15 was provided with incontinent care as well as a shower on 5/21/2018. There were no negative outcomes as a result of this deficiency 2. Root Cause: The staff failed to assist the resident to the restroom in timely manner due to her transfer status not being clear amongst staff members. The time that elapsed during the validation of transfer status caused the resident to have an episode of incontinence. An audit was conducted on other residents residing in the facility on 5-22-2018 through 5-25-2018 and no residents were found to be soiled. 3. The DON/designee will conduct	6/13/18

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F 677	Continued From page 23 Guide) revealed that on 05/21/18 Resident #15 needed the limited assistance of one person for toileting needs and needed the limited assistance of one person for transfers. In an observation on 05/21/18 at 8:40 AM the call light above the door of Resident #15's room was lit up. A male staff member walked past the room without acknowledging the light. Two female staff members were at the end of the hallway speaking together. The call light was lit up on the panel at the nurse's station and the alarm was sounding. No staff members were at the nurse's station. Resident #15 was sitting on the bed with her legs thrown over the side of the bed. The head of the bed was elevated and she was leaning against the mattress in an awkward appearing position. Resident #15 was wearing a brief. She indicated she needed to use the bathroom but could not get out of the bed on her own to get to the bathroom. At 8:45 AM the MDS Nurse entered Resident #15's room and was told by the resident that she needed to use the bathroom. At 8:50 AM the MDS Nurse left the room after informing Resident #15 that she was going to check on how the resident was transferred. At 8:53 AM the MDS Nurse came back to the room with some linens. At 8:59 AM the MDS Nurse left the room after explaining to Resident #15 that a resident from the room next door was now in the adjoining bathroom and that she (Resident #15) would need to wait to use the bathroom. The MDS Nurse informed Resident #15 the aide that was helping the resident next door had been told to let staff know when the bathroom was available for Resident #15's use. At 9:06 AM the Speech Therapist (ST) came to Resident #15's room. She indicated Resident #15 had a mild stroke approximately five days prior but was recovering	F 677	re-education with nursing staff by 6/11/2018 on providing timely incontinence care and accessing current resident transfer status. Audits will be conducted 3 times a week on providing timely incontinence care for 12 weeks. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 677	Continued From page 24 quickly. At 9:10 AM the Rehabilitation Aide (RA) came to Resident #15's room. She indicated she was not assigned to Resident #15 that day but had been told by a staff member (she was unable to remember who) to see if the resident needed assistance with transferring to the bathroom. The bathroom became available for Resident #15 to use. At 9:11 AM the RA left Resident #15's room stating she would find out how the resident transferred. At 9:14 AM the Rehabilitation Director came into Resident #15's room. She informed Resident #15 that the Physical Therapist (PT) (on 05/16/18) had changed her transfer status to a two person mechanical lift transfer following her recent stroke and that the lift could not be used to take her into the bathroom in her room because the mechanical lift would not fit in the bathroom. The Rehabilitation Director indicated that Resident #15 would probably feel more comfortable with the PT she was familiar with and he was sent for. Resident #15 indicated that she had not been transferred to the bathroom using the mechanical lift and did not want to use it because she was afraid it would injure her leg. At 9:20 AM Resident #15 indicated that she had already wet herself because she could no longer hold it. She stated at first it bothered her when she wet herself but now she was used to it because it always took staff a long time to help her and she was used to it. At 9:28 AM the PT came to Resident #15's room with a walker and she was assisted to sit on the edge of the bed in preparation for transfer into a wheelchair. The PT indicated that the nursing staff was supposed to use the mechanical lift for transfers and only the therapists could transfer Resident #15 using a walker. Resident #15 was still requesting to use the bathroom so the PT decided to transfer her into the wheelchair and	F 677		

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F 677	Continued From page 25 take her to the shower room where she could be transferred to a shower chair and placed over the toilet. Resident #15 was assisted to stand in preparation for transfer to the wheelchair. The back of her gown was noted to be saturated with urine. The brief that Resident #15 wore appeared to be saturated with urine. There was a fabric lined, plastic backed, incontinence pad over a folded in quarters bath blanket on top of the bottom sheet. The bath blanket and incontinence pad were both saturated with urine. The bottom sheet was wet from the shoulder area to the mid-thigh area. The Rehabilitation Director removed the saturated linens and rivulets of urine were noted on the mattress. A strong smell of urine was noted at the time the linens were exposed. The Rehabilitation Director offered Resident #15 a shower and stated it was not acceptable that Resident #15 was found in that condition. At 9:36 AM Resident #15 was taken to the shower room where she required the assistance of three staff members to stand. At 9:39 AM the saturated brief was removed and Resident #15 was placed in a shower chair over the toilet to use the bathroom. When the brief was removed Resident #15's buttocks were noted to be red but there was no breakdown. Resident #15 stated her buttocks were red because she had laid in urine for so long. Throughout the continuous observation there had never been any offer of a bedpan or to check Resident #15's brief to see if incontinence care could be provided while her transfer status was being established. In an interview on 05/21/18 at 10:28 AM Nursing Assistant (NA) #1 indicated she had checked Resident #15 at approximately 7:30 AM by looking at the front of the brief for a color change on the moisture indicator line. There was no	F 677		

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F 677	Continued From page 26	F 677		

change in color to indicate that Resident #15 had been incontinent of urine. She indicated she fed Resident #15's roommate her breakfast and told Resident #15 she would be back to provide care. NA #1 stated Resident #15 did not tell her she was wet when she served her breakfast. She indicated she had used the mechanical lift to get Resident #15 out of bed on 05/19/18.

In an interview on 05/21/18 at approximately 10:35 AM the Director of Nursing (DON) stated the care guides for each resident were only in the computer. She stated the nursing staff all had access to the information and should be going into the computer to see how to care for the residents.

In an interview on 05/22/18 at 9:51 AM the Occupational Therapist (OT) stated the nursing staff was supposed to use a mechanical lift to transfer Resident #15.

In an interview on 05/24/18 at 5:18 PM the MDS Nurse stated that a lot of things had been discussed about Resident #15 in clinical meetings. She indicated she remembered a discussion that Resident #15 may or may not be appropriate for therapy but did not remember any discussion about the use of a mechanical lift so was not aware Resident #15 needed one for transfers. She indicated she and the MDS Coordinator were responsible for updating the care guides but since a significant change MDS was in process Resident #15's care plans and care guide had not yet been updated.

In an interview on 05/22/18 at 6:00 AM NA #4 stated incontinence rounds were conducted every two hours and as needed.

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F 677	Continued From page 27 In an interview on 05/22/18 at 6:20 AM NA #6 indicated she went non-stop during her shift providing care. She stated she checked on her residents more often than every two hours. In an interview on 05/25/18 at 1:10 PM NA #8 stated she had found Resident #15 saturated before when she took over her assignment. She indicated she had informed the hall nurse and the DON. She stated rounds should be done every two hours to check residents for incontinence. In an interview on 05/25/18 at 2:05 PM the DON stated she expected incontinence rounds to be completed every two hours and as needed. She indicated she would not expect aides to pull back a resident's brief to check for incontinence. She stated that visualizing a change in color to the moisture line in the brief was sufficient if there was no odor. The DON indicated it should not have taken so long for Resident #15 to be taken to the bathroom or for her to receive incontinent care.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		6/13/18

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F 684	Continued From page 28 Based on observations, record review and staff interviews, the facility failed to follow patient centered care plans to apply palm protectors to 2 of 3 residents (Resident #19 and #9) observed for range of motion and contractures. Findings included: Example #1 Resident #19 was admitted to the facility on 10/10/06. Diagnosis included hemiplegia, neuromuscular dysfunction and right and left hand contractures. The Minimum Data Set (MDS) dated 03/26/18, 14-day assessment revealed the resident was cognitively impaired. Resident #19 required extensive assistance with two staff assist with transfers, bed mobility, toileting and bathing, and extensive assistance with one staff assist with dressing, eating and personal hygiene. Resident #19 had impairments to both sides to upper and lower extremities. Resident #19 was not coded for any splinting or range of motion. A review of the physician orders revealed an order was written on 04/18/18 for bilateral palm protectors to be on at all times per patient tolerance. A review of the care plan updated on 04/20/18 revealed the resident had a potential for skin breakdown development related to decreased mobility with an intervention to include bilateral palm protectors to be worn at all times and removed for hand hygiene and monitor for redness.	F 684	F684 1. Resident's #19 and #9 have splints on as ordered. Neither Resident had a negative outcome as a result of this observation. 2. Root Cause: There was miss communication between the licensed nurses and the certified nursing assistants as to who would apply the splinting devices daily. The restorative nursing staff will apply splinting devices going forward. An audit was completed on like residents to ensure that devices were in place on 6/4/2018 3. The DON/Designee will conduct re-education on ensuring all devices are applied per directions by 6/11/18. Audits will be conducted 3 times a week for 12 weeks to ensure splints are applied as ordered. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 684	Continued From page 29 An observation of Resident #19 on 05/20/18 at 1:42 PM revealed there were no palm protectors on bilateral hands. The resident ' s hands were noted to be contracted, fingernails were clean and trim and there were no signs of indentation or odor on her palms. An observation of Resident #19 on 05/20/18 at 4:45 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 8:50 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 10:30 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 12:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 2:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 4:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 5/22/18 at 8:30 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/22/18 at 10:15 AM revealed there were no palm protectors on bilateral hands. An observation on Resident #19 on 05/22/18 at	F 684		

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1:20 PM revealed there were no palm protectors on bilateral hands.

An interview with NA #2 on 05/22/18 at 2:30 PM revealed Resident #19 was total care and she relied on staff assistance for all of her care. NA #2 stated Resident #19 wore bunny boots to her bilateral feet, but she was not aware if the resident wore splints or anything on her hands. NA #2 stated she was fed with assistance and could use her hands to hold a special cup. NA #2 reported the only way she knew how to take care of a resident was if she already knew them or she would ask the nurse.

An observation of Resident #19 on 05/23/18 at 6:00 AM revealed there were no palm protectors on bilateral hands.

An interview with Nurse #8 on 05/23/18 at 6:10 AM revealed "She was supposed to have them on at all times." The nurse searched the room for the palm protectors which were located in a bureau draw and applied them to the resident. Nurse #8 stated it was a nursing measure and it was up to the nurse to apply the palm protectors.

An interview was conducted with the Director of Nursing (DON) on 05/24/18 at 2:30 PM. The DON reported her expectations of the nursing staff was to follow the care plan and to ensure the palm protectors were applied as ordered by the physician.

Example 2

Resident #9 was admitted to the facility on 08/15/17 and re-entered on 03/03/18 with

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diagnoses that included multiple sclerosis, right nondominant side hemiplegia and right hand contracture.

The May 2018 current physician orders regarding the resident's palm protector was: "Right palm protector on at all times as tolerated by the resident, remove for hygiene and check for redness."

A quarterly Minimum Data Set assessment (MDS) dated 02/21/18 revealed the resident had intact cognition, required extensive assistance for all activities of daily living except eating, and had bilateral upper and lower extremity impairments.

Review of the care plan dated 03/05/18 for Resident #9 stated that he was at risk for impaired skin integrity related to poor bed mobility due to multiple sclerosis and a right hand contracture. Interventions included: palm protector to the right hand, remove for hand hygiene and monitor for redness.

On 05/20/18 at 11:45 AM and on 05/23/18 at 8:30 AM Resident #9 was observed without a palm protector on his right hand.
In an interview with Resident #9 on 05/23/18 at 8:30 AM he stated that his palm protector had fallen on the floor beside his bed about a week ago and he had not seen it since. He stated that he did wear it except when wheeling his wheelchair and when eating but had not had it to put on for a week. He said his hand felt better when he had it on.

On 5/23/18 at 5:30 PM the resident stated that he had received a new palm protector for his hand and showed it to this surveyor. He said he had

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F 684	Continued From page 32 just taken it off because dinner was coming and he was going to eat. In an interview conducted with the Director of Nursing on 05/24/18 at 12:05 PM she stated that the nurse aides applied splints and palm guards. She said they documented this task in the electronic Point of Care (POC) system Kardex. She said it was her expectation that if a palm protector was ordered by the physician that it be applied by the nurse aides as ordered and care planned In an interview with Nurse Aide #9 on 05/25/18 at 7:50 AM she stated that she obtained information regarding specific patient care by looking in POC or asking a nurse. She said if a resident had a palm guard or a splint it would show in POC as a task to be done. She reported that she cared for Resident #9. She said that she remembered that he wore a palm guard and that she was "pretty sure" that she saw it and put it on his hand while providing care but could not say for certain. In an interview with Nurse Aide #10 on 05/25/18 at 8:05 AM she stated that she cared for Resident #9 on her assignment. She said she looked at the resident Kardex to determine the needs of each resident. She remembered that Resident #9 wore a palm guard on his right hand. She stated that she could not remember if he was wearing the palm guard the last time she took care of him. She said she did remember seeing it on his dresser but could not remember putting it on the resident.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		6/13/18

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F 688	Continued From page 33 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply ordered palm protectors to 2 of 3 residents (Resident #19 and #9) observed for range of motion and contractures. Findings included: Example #1 Resident #19 was admitted to the facility on 10/10/06. Diagnosis included hemiplegia, neuromuscular dysfunction and right and left hand contractures. The Minimum Data Set (MDS) dated 03/26/18, 14-day assessment revealed the resident was cognitively impaired. Resident #19 required extensive assistance with two staff assist with	F 688	F688 1. Resident's #19 & #9 had splints applied as ordered and documentation is accurately recorded. Neither Resident had a negative outcome as a result of this observation. 2. Root Cause: There was miss communication between the licensed nurses and the certified nursing assistants as to who would apply the splinting devices daily. Nursing staff documented splint application without validating device was in place. The restorative nursing staff will apply splinting devices going forward. An audit was completed on like residents to ensure that devices were in place on 6/4/2018. 3. The DON/Designee will conduct re-education on ensuring all devices are	

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transfers, bed mobility, toileting and bathing, and extensive assistance with one staff assist with dressing, eating and personal hygiene. Resident #19 had impairments to both sides to upper and lower extremities. Resident #19 was not coded for any splinting or range of motion.

A review of the physician orders revealed an order written on 04/18/18 for bilateral palm protectors to be on at all times per patient tolerance.

A review of the care plan updated on 04/20/18 revealed the resident had a potential for skin breakdown development related to decreased mobility with an intervention to include bilateral palm protectors to be worn at all times and removed for hand hygiene and monitor for redness.

An observation of Resident #19 on 05/20/18 at 1:42 PM revealed there were no palm protectors on bilateral hands. The resident ' s hands were noted to be contracted, fingernails were clean and trim and there were no signs of indentation or odor on her palms.
An observation of Resident #19 on 05/20/18 at 4:45 PM revealed there were no palm protectors on bilateral hands.

An observation of Resident #19 on 05/21/18 at 8:50 AM revealed there were no palm protectors on bilateral hands.

An observation of Resident #19 on 05/21/18 at 10:30 AM revealed there were no palm protectors on bilateral hands.

An observation of Resident #19 on 05/21/18 at

F 688

applied per directions and that the nurse validates the device is in place before documentation can be completed this will be completed by 6/11/18. Audits will be conducted 3 times a week for 12 weeks to ensure splints are applied as ordered
4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.

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F 688	Continued From page 35 12:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 2:30 PM revealed there were no palm protectors on bilateral hands. A review of the Treatment Administration Record (TAR) revealed Nurse #5 initialed the task to apply palm protectors to bilateral hands on 05/21/18 for the day shift. An observation of Resident #19 on 05/21/18 at 4:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 5/22/18 at 8:30 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/22/18 at 10:15 AM revealed there were no palm protectors on bilateral hands. An observation of the TAR at 11:00 AM revealed Nurse #5 initialed the task to apply palm protectors to bilateral hands on 05/22/18 for the day shift. An observation on Resident #19 on 05/22/18 at 1:20 PM revealed there were no palm protectors on bilateral hands. An interview with NA #2 on 05/22/18 at 2:30 PM revealed Resident #19 was total care and she relied on staff assistance for all of her care. NA #2 stated Resident #19 wore bunny boots to her bilateral feet, but she was not aware if the resident wore splints or anything to her hands.	F 688		

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NA #2 stated she was fed with assistance and could use her hands to hold a special cup. NA #2 reported the only way she knew how to take care of a resident was if she already knew them or she would ask the nurse.
An observation on Resident #19 on 05/22/18 at 5:30 PM revealed there were no palm protectors on bilateral hands.

An observation of Resident #19 on 05/23/18 at 6:00 AM revealed there were no palm protectors on bilateral hands.

An observation of the TAR at 6:10 AM revealed Nurse #8 initialed the task to apply palm protectors to bilateral hands on 05/23/18 for the night shift.

An interview with Nurse #8 on 05/23/18 at 6:10 AM revealed the process of signing off a task or medication to confirm that it was completed was to check it off in the computer. Nurse #8 stated a check mark would show up if it was done. Nurse #8 explained that if the task was not done, a code number would appear to prompt the nurse to enter a reason for the task not being completed as ordered. Nurse #8 reported this particular task (applying bilateral palm protectors) was done and that was why there was a check mark. Nurse #8 observed the resident at this time and noted the palm protectors were not on the resident and stated "Oh, did they take them off?" "She wears them bilateral? I thought it was just one hand." And then stated, "She was supposed to have them on at all times." The nurse searched the room for the palm protectors which were located in a bureau draw and applied them to the resident. Nurse #8 stated it was a nursing measure and it was up to the nurse to apply

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them.

An interview with Nurse #4 on 05/23/18 at 10:50 AM reported she was assigned to Resident #19 on 05/22/18. Nurse #4 stated she did not apply the palm protectors during the day shift for Resident #19 because it was Nurse #5 ' s responsibility because it was considered a treatment. Nurse #4 stated it was a nursing measure to apply the palm protectors.

An interview with Nurse #5 on 05/23/18 at 11:00 AM revealed she signed the task off as being completed on 05/21/18 and 05/22/18 because the palm protectors were on her. Nurse #5 stated she did not apply them, but saw them on her. Nurse #5 could not recall the time that she observed the palm protectors on the resident.

An interview was conducted with Director of Nursing (DON) on 05/24/18 at 2:30 PM. The DON reported her expectations of the nursing staff was to apply the palm protectors as ordered by the physicians.
Example 2

Resident #9 was admitted to the facility on 08/15/17 and re-entered on 03/03/18 with diagnoses that included multiple sclerosis, right nondominant side hemiplegia and right hand contracture.

The May 2018 current physician orders regarding the resident's palm protector was: "Right palm protector on at all times as tolerated by the resident, remove for hygiene and check for redness."

A quarterly Minimum Data Set assessment

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F 688	Continued From page 38 (MDS) dated 02/21/18 revealed the resident had intact cognition, required extensive assistance for all activities of daily living except eating, and had bilateral upper and lower extremity impairments. Review of the care plan dated 03/05/18 for Resident #9 stated that he was at risk for impaired skin integrity related to poor bed mobility due to multiple sclerosis and a right hand contracture. Interventions included: palm protector to the right hand, remove for hand hygiene and monitor for redness. On 05/20/18 at 11:45 AM and on 05/23/18 at 8:30 AM Resident #9 was observed without a palm protector on his right hand. In an interview with Resident #9 on 05/23/18 at 8:30 AM he stated that his palm protector had fallen on the floor beside his bed about a week ago and he had not seen it since. He stated that he did wear it except when wheeling his wheelchair and when eating but had not had it to put on for a week. He said his hand felt better when he had it on. On 5/23/18 at 5:30 PM the resident stated that he had received a new palm protector for his hand and showed it to this surveyor. He said he had just taken it off because dinner was coming and he was going to eat. In an interview conducted with the Director of Nursing on 05/24/18 at 12:05 PM she stated that the nurse aides applied splints and palm guards. She said they documented this task in the electronic Point of Care (POC) system Kardex. She said it was her expectation that if a palm protector was ordered by the physician that it be applied by the nurse aides as ordered. She reported that she had gone into Resident #9's room on 05/23/18 and had found his old palm	F 688		

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F 688	Continued From page 39 guard in his closet but that he had also been issued a new one that day to wear. In an interview with Nurse Aide #9 on 05/25/18 at 7:50 AM she stated that she obtained information regarding specific patient care by looking in POC or asking a nurse. She said if a resident had a palm guard or a splint it would show in POC as a task to be done. She reported that she cared for Resident #9. She said that she remembered that he wore a palm guard and that she was "pretty sure" that she saw it and put it on his hand while providing care but could not say for certain. In an interview with Nurse Aide #10 on 05/25/18 at 8:05 AM she stated that she cared for Resident #9 on her assignment. She said she looked at the resident Kardex to determine the needs of each resident. She remembered that Resident #9 wore a palm guard on his right hand. She stated that she could not remember if he was wearing the palm guard the last time she took care of him. She said she did remember seeing it on his dresser.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		6/13/18

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F 732	Continued From page 40 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post accurate nurse staffing. Findings included: An observation made on entrance to the facility on 05/20/18 at 11:00 AM revealed that the nurse staffing sheet displayed in the main hallway was dated 05/18/18. In an interview on 5/20/18 at 11:30 AM with Nurse #8, who was working at the nursing station adjacent to the posting, she stated that the posting was old and had not been changed. She	F 732	F732 1. Upon identification that the staffing sheet was not posted as per requirements, the staffing sheet was posted. 2. Root cause: The facility failed to assign the duty of posting nursing staffing. The weekend manager will now be responsible for ensuring staffing sheets are posted. There were no residents affected by this observation. 3. Re education was provided to the Administrative staff by the NHA regarding the daily staffing sheets that need to be	

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F 732	Continued From page 41 said she was not the charge nurse and did not know who was supposed change the staffing sheet each day. In an interview with the Director of Nursing (DON) on 5/20/18 at 12:45 PM she stated that during the week, (Monday through Friday), she changed the nurse staffing sheet that was posted in the hallway. She said she did not do it on the weekends and had not assigned the duty to anyone specific. Going forward the DON said she would assign this duty to a specific nurse to ensure that the correct posting was displayed every day including weekends.	F 732	posted. Education will be completed by 6/11/2018. Audits will be conducted 3 times a week for 12 weeks to ensure staffing sheets are posted per requirements 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and physician interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.69% for 1 of 5 sampled residents (Resident #65) observed during medication administration. Findings included: During a medication administration observation on 05/24/18 at 8:56 AM Nurse #1 was observed passing medications to Resident #65. Prior to the administration of medications Nurse #1 obtained Resident #65's blood pressure. Nurse #1	F 759	F759 1. Notification was provided to the MD regarding the administration of the Clonidine to Resident #65. Clarification was obtained from the MD and the parameters for the blood pressure medications were discontinued. There were no negative outcomes as a result of this 2. Root Cause: There was a transcription error that lead to the medication error for Labetalol. Nurse #1 failed to read the special instructions attached to the medication orders prior to administering	6/13/18

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F 759	Continued From page 42 verbalized the blood pressure reading was 140/86 (systolic/diastolic). She pulled out Resident #65's labetalol 200mg (milligrams) bubble pack sent by the pharmacy. She verified the medication was for Resident #65 and that it was the correct dosage according to the electronic Medication Administration Record (MAR). There was a sticker on the bubble pack from the pharmacy with special instructions. The instructions read to hold the medication if the diastolic blood pressure reading was less than 100. Resident #65's diastolic blood pressure was 86. Nurse #1 placed the medication in a small cup for administration to Resident #65. Nurse #1 also placed clonidine 0.3mg in the cup to give to Resident #65 after verifying it was the correct dosage according to the MAR. There were no special instructions listed on the pharmacy bubble pack for the clonidine. Nurse #1 stated she was ready to provide medications to Resident #65. At this point Nurse #1 was requested to stop the medication administration and to pull out the bubble pack containing the labetalol. She was asked to read the special instructions supplied by the pharmacy. After reading the special pharmacy instructions she stated she had not seen the label and reviewed the electronic MAR. She verified the electronic MAR contained instructions to hold the labetalol if the diastolic blood pressure was less than 100. She indicated she would hold the labetalol and speak with Resident #65's physician for clarification on the parameters for administering the medication. Nurse #1 continued with the medication administration for Resident #65 without the labetalol. During medication reconciliation (medications given are compared to what was ordered) on	F 759	medications. There were no other residents observed with similar findings. Nurse #1 received disciplinary action on 5/30/2018. 3. Education was provided to Nurse #1 on following MD orders and validating medication package instruction with written instructions in eMAR. Nurses will be provided re education on medication administration and reviewing special instruction in the eMAR by the DON. Education will be completed by 6/11/18. Medication administration audits will be conducted 3 times a week for 12 weeks to ensure medication are administered per Physicians orders and any listed parameters are followed. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 759	Continued From page 43 05/24/18 at approximately 9:15 AM it was discovered that Resident #65's clonidine also had special blood pressure parameter orders. The order showed the clonidine 0.3mg should be held if the diastolic blood pressure was less than 100. Nurse #1 was approached and verified by checking the MAR for special instructions that the order included blood pressure parameters and that she should have also held the clonidine. In an interview on 05/24/18 at 9:32 AM Resident #65's physician stated he expected his orders to be followed. He indicated that although he felt that the diastolic and systolic parameters for Resident #65's blood pressure had just been transposed, someone should have called him to verify the parameters of the order. In an interview on 05/25/18 at 8:42 AM Nurse #1 stated she should have read the complete order in the electronic MAR and clarified the blood pressure parameters prior to administering the medications. In an interview on 05/25/18 at 2:05 PM the Director of Nursing (DON) stated she expected the facility medication error rate to be less than 5%. She indicated she expected medications to be given as ordered and for parameters to be followed. The DON indicated if there were questions regarding medications or parameters she expected the nurses to obtain clarification from the physician.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/13/18

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F 812	Continued From page 44 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep a cold salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the trayline. The facility also failed to air dry kitchenware before stacking it in storage, and failed to label and date opened and repackaged food items in storage areas. Findings included: 1. Upon entering the kitchen on 05/22/18 at 5:22 PM a deep tray pan of Cole slaw was observed in a well of the steam table above a shallow pan of melting ice and next to a well housing hot foods, and five preplated dishes which included bowls of Cole slaw were sitting on the edge of the steam table waiting to be placed on resident trays. At 5:25 PM on 05/22/18 a calibrated thermometer used to check the tray pan of Cole slaw registered 46.5 degrees Fahrenheit. The same	F 812	F812 1. Following identification of the undated food items, dry stock items and improperly dried trays appropriate corrective action took place. Upon identification that the slaw exceeded temperature it was disposed of. No residents were affected by this deficient practice. 2. Root Cause: Dietary employees failed to follow outlined guidance on food storage and preparation as well as proper drying of dishes. The employees were able to explain proper procedures to the administrator. Disciplinary actions will be provided. 3. Dietary staff was provided with re education on: dating food items, proper food handling (including cold foods) and proper drying procedures on 5/20/2018 and 5/291/2018. Audits will be conducted	

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F 812	Continued From page 45 thermometer registered 68.2 degrees Fahrenheit when used to check the last bowl of preplated Cole slaw to be placed on a resident tray. At 5:28 PM on 05/22/18 the PM Cook stated the dietary staff still had 1 1/2 meal carts to send out for residents. He reported that he finished assembling the slaw at about 1:00 PM on 05/22/18, and placed it in the walk-in refrigerator to chill. He commented that all the ingredients he utilized in the preparation were chilled prior to assembly. The Cook stated that the Cole slaw contained diced cabbage, carrots, mayonnaise, vinegar, and sugar. The Cook reported that he recorded the temperature of the slaw at 40 degrees Fahrenheit when the supper trayline initially began operation at 5:00 PM. At 5:34 PM on 05/22/18 the Dietary Manager (DM) stated when he took the temperature of the Cole slaw prior to the supper trayline beginning operation the calibrated thermometer actually registered 37 degrees Fahrenheit. At 2:35 PM on 05/23/18 the DM stated the dietary staff was trained to use chilled ingredients when preparing cold salads, and that it was preferable to prepare them a day before they were served to residents. He reported staff usually placed cold salads over ice in a steam well once the trayline began operation. He commented that from a temperature control standpoint it was probably best not to place all the chilled salad in one big tray pan. According to the DM, allowing cold salads made with mayonnaise to rise above 41 degrees Fahrenheit for long periods of time could cause the spread of foodborne illness. At 2:57 PM on 05/23/18 a dietary employee	F 812	3 times a week for 12 weeks to ensure kitchen policies are followed to include storage of food, labeling of food, preparations of hot and cold items and proper drying of dishes. 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as deemed necessary/appropriate by this committee.	

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F 812	Continued From page 46 stated cold salads should be prepared the day before they were served, or at the latest they should be assembled in the early morning on the day they were due to be served. Once assembled, he reported the salads were supposed to be stored in refrigeration until the meal trayline began operation, and then they were to be kept in or above ice once the trayline process began. The employee commented allowing cold salads to rise above 41 degrees Fahrenheit for long periods of time could cause bacteria and fungus to grow in the food. 2. During initial tour of the kitchen, beginning at 11:23 AM on 05/20/18, 6 of 12 tray pans stacked on top of one another on a shelving unit had moisture trapped inside of them. At this time the AM cook reported these tray pans were stacked wet on the evening of 05/19/18, and retained moisture inside of them overnight. At 2:35 PM on 05/23/18 the Dietary Manager (DM) stated dietary employees were trained to air dry all kitchenware before stacking it in storage. He reported stacking kitchenware wet overnight could cause bacterial formation and result in residents getting sick. At 2:57 PM on 05/23/18 a dietary employee stated there should be absolutely no moisture present when kitchenware was stacked in storage. He reported the dietary staff was taught to use drying racks and fans to promote the drying of kitchenware which had been run through the dish machine and three-compartment sink process. He commented that stacking kitchenware wet could cause the formation of bacteria and fungus which could make residents sick if ingested.	F 812		

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F 812	Continued From page 47 3. During initial tour of the kitchen, beginning at 11:23 AM on 05/20/18, hot dog buns and potato chips which were opened and stored above a food preparation table were without labels and open dates. In the reach-in refrigerator three containers of pink lemonade did not have labels and dates on them. In the dry storage room three bags of ziti pasta, 2 bags of tri-color rotini pasta, one bag of elbow macaroni, and a 5-pound container of dry/powdered milk were opened, but did not have labels or open dates posted on them. In the walk-in refrigerator one gallon of mayonnaise, one gallon of Cole slaw dressing, one gallon of lite Italian dressing, one gallon of sweet pickle relish, one gallon of Caesar dressing, and one gallon of thousand island dressing were opened, but were without labels documenting the dates on which they were initially opened up. In the walk-in freezer a brown bag of waffle fries had been opened, but was without a label and date on it. During a follow-up tour of the kitchen, at 9:48 AM on 05/23/18, one gallon of mayonnaise, one gallon of Cole slaw dressing, one gallon of lite Italian dressing, one gallon of Caesar dressing, and one gallon of thousand island dressing, stored in the walk-in refrigerator, were opened, but did not have labels on them documenting when they were initially opened. At 2:35 PM on 05/23/18 the Dietary Manager (DM) stated he and his assistant monitored storage areas daily when they were working, and that all opened food items, repackaged food items, and leftovers were supposed to have labels and dates on them. He also reported the	F 812		

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F 812	Continued From page 48 stock person monitored storage areas once weekly for labeling and dating, and the cooks were trained to place food from opened packages in storage bags with labels and dates to be affixed to these bags. According to the DM, dating and labeling was important in the "first in, first out" (FIFO) concept which promoted serving the freshest food possible. At 2:57 PM on 05/23/18 a dietary employee stated all employees were supposed to monitor storage areas for labeling and dating as they went in and out of the dry storage room, reach-in coolers, and walk-in refrigerators and freezers. He reported labeling and dating was important to keep stock rotated properly.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		6/13/18

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F 842	Continued From page 49	F 842		

§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-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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F 842	Continued From page 50 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility inaccurately documented a task as completed on the Treatment Administration Record for 2 of 3 residents (Resident #19 and #9) observed for the application of palm protectors to be applied to bilateral hands at all times. Findings included: Example #1 Resident #19 was admitted to the facility on 10/10/06. Diagnosis included hemiplegia, neuromuscular dysfunction and right and left hand contractures. The Minimum Data Set (MDS) dated 03/26/18, 14-day assessment revealed the resident was cognitively impaired. Resident #19 required extensive assistance with two staff assist with transfers, bed mobility, toileting and bathing, and extensive assistance with one staff assist with dressing, eating and personal hygiene. Resident #19 had impairments to both sides to upper and lower extremities. Resident #19 was not coded for any splinting or range of motion at the time of this look back period. A review of the physician orders revealed an order written on 04/18/18 for bilateral palm	F 842	F842 1. Resident's #19 & #9 had splints applied as ordered and documentation is accurately recorded. Neither Resident had a negative outcome as a result of this observation. 2. Root Cause: There was miss communication between the licensed nurses and the certified nursing assistants as to who would apply the splinting devices daily. Nursing staff documented splint application without validating device was in place. The restorative nursing staff will apply splinting devices going forward. An audit was completed on like residents to ensure that devices were in place on 6/4/2018. 3. The DON/Designee will conduct re-education on ensuring all devices are applied per directions and that the nurse validates the device is in place before documentation can be completed this will be completed by 6/11/18. Audits will be conducted 3 times a week for 12 weeks to ensure splints are applied as ordered 4. The QA team will review, analyze and report the results at the monthly performance improvement committee meetings to validate compliance is achieved and sustained. Subsequent plans of correction will be implemented as	

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F 842	Continued From page 51 protectors to be on at all times per patient tolerance. A review of the care plan updated on 04/20/18 revealed the resident had a potential for skin breakdown development related to decreased mobility with an intervention to include bilateral palm protectors to be worn at all times and removed for hand hygiene and monitor for redness. An observation of Resident #19 on 05/20/18 at 1:42 PM revealed there were no palm protectors on bilateral hands. The resident ' s hands were noted to be contracted, fingernails were clean and trim and there were no signs of indentation or odor on her palms. An observation of Resident #19 on 05/21/18 at 8:50 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 10:30 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 12:30 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/21/18 at 2:30 PM revealed there were no palm protectors on bilateral hands. A review of the Treatment Administration Record (TAR) revealed Nurse #5 initialed the task to apply palm protectors to bilateral hands on 05/21/18 for the day shift.	F 842	deemed necessary/appropriate by this committee.	

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F 842	Continued From page 52 An observation of Resident #19 on 5/22/18 at 8:30 AM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/22/18 at 10:15 AM revealed there were no palm protectors on bilateral hands. A review of the TAR at 11:00 AM revealed Nurse #5 initialed the task to apply palm protectors to bilateral hands on 05/22/18 for the day shift. An observation on Resident #19 on 05/22/18 at 1:20 PM revealed there were no palm protectors on bilateral hands. An observation of Resident #19 on 05/23/18 at 6:00 AM revealed there were no palm protectors on bilateral hands. A review of the TAR at 6:10 AM revealed Nurse #8 initialed the task to apply palm protectors to bilateral hands on 05/23/18 for the night shift. An interview with Nurse #8 on 05/23/18 at 6:10 AM revealed the process of signing off a task or medication to confirm that it was completed was to check it off in the computer. Nurse #8 stated a check mark would show up if it was done. Nurse #8 explained that if the task was not done, a code number would appear to prompt the nurse to enter a reason for the task not being completed as ordered. Nurse #8 reported this particular task (applying bilateral palm protectors) was done and that was why there was a check mark. Nurse #8 observed the resident at this time and noted the palm protectors were not on the resident and stated "Oh, did they take them off?" "She wears them bilateral? I thought it was just one hand."	F 842		

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F 842	Continued From page 53 And then stated, "She is supposed to have them on at all times." The nurse searched the room for the palm protectors which were located in a bureau draw and applied them to the resident. Nurse #8 stated it was a nursing measure and it was up to the nurse to apply them. The nurse reported she should not have signed the task off without applying the palm protectors. An interview with Nurse #4 on 05/23/18 at 10:50 AM reported she was assigned to Resident #19 on 05/22/18 and 05/23/18. Nurse #4 stated she did not apply the palm protectors on the day shift on Resident #19 because it was Nurse #5 ' s responsibility because it was considered a treatment. Nurse #4 stated it was a nursing measure to apply the palm protectors. Nurse #4 stated if there were initials in the box with a check mark on the TAR, then that would mean the task was completed. Nurse #4 reported that nurses are not supposed to sign off a medication or treatment until they have completed it. An interview with Nurse #5 (treatment nurse) on 05/23/18 at 11:00 AM revealed she signed the task off as being completed on 05/21/18 and 05/22/18 because the palm protectors were on her. Nurse #5 stated she did not apply them, but saw them on her. Nurse #5 confirmed her initials were in the box on the TAR. Nurse #5 stated if there were initials and a check mark it indicated the task was completed. Nurse #5 could not recall the time that she observed the palm protectors on the resident. Nurse #5 stated the protocol was to not sign off the treatment until it was completed. An interview was conducted with the Director of Nursing (DON) on 05/24/18 at 2:30 PM. The	F 842		

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F 842	Continued From page 54 DON reported her expectations of the nursing staff was to complete the task as ordered on the TAR before signing it off that it was done. The DON stated they should not sign off a task until they have completed it. Example 2 Resident #9 was admitted to the facility on 08/15/17 and re-entered on 03/03/18 with diagnoses that included multiple sclerosis, right nondominant side hemiplegia and right hand contracture. The May 2018 current physician orders regarding the resident's palm protector was: "Right palm protector on at all times as tolerated by the resident, remove for hygiene and check for redness." A quarterly Minimum Data Set assessment (MDS) dated 02/21/18 revealed the resident had intact cognition, required extensive assistance for all activities of daily living except eating, and had bilateral upper and lower extremity impairments. Review of the care plan dated 03/05/18 for Resident #9 stated that he was at risk for impaired skin integrity related to poor bed mobility due to multiple sclerosis and a right hand contracture. Interventions included: palm protector to the right hand, remove for hand hygiene and monitor for redness. On 05/20/18 at 11:45 AM and on 05/23/18 at 8:30 AM Resident #9 was observed without a palm protector on his right hand. In an interview with Resident #9 on 05/23/18 at 8:30 AM he stated that his palm protector had fallen on the floor beside his bed about a week ago and he had not seen it since. He stated that he did wear it except when wheeling his wheelchair and when eating but had not had it to put on for a week. He said his hand felt better when he had it on.	F 842		

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F 842	Continued From page 55 On 5/23/18 at 5:30 PM the resident stated that he had received a new palm protector for his hand and showed it to this surveyor. He said he had just taken it off because dinner was coming and he was going to eat. In an interview conducted with the Director of Nursing on 05/24/18 at 12:05 PM she stated that the nurse aides applied splints and palm guards. She said they documented this task in the electronic Point of Care (POC) system Kardex. She said it was her expectation that if a palm protector was ordered by the physician that it be applied by the nurse aides as ordered. She stated that she expected the documentation in POC to reflect the actual care delivered to a resident. She did not expect documentation to show that a palm guard was on a resident if it was not. In an interview with Nurse Aide #9 on 05/25/18 at 7:50 AM she stated that she obtained information regarding specific patient care by looking in POC or asking a nurse. She said if a resident had a palm guard or a splint it would show in POC as a task to be done. She reported that she cared for Resident #9. She said that she remembered that he wore a palm guard and that she was "pretty sure" that she saw it and put it on his hand while providing care but could not say for certain and that is why she signed that the device was in place (on the resident's hand) on 05/21/18 at 00:56. In an interview with Nurse Aide #10 on 05/25/18 at 8:05 AM she stated that she cared for Resident #9 on her assignment. She said she looked at the resident Kardex to determine the needs of each resident. She remembered that Resident #9 wore a palm guard on his right hand. She stated that she could not remember if he was wearing the palm guard the last time she took	F 842		

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F 842	Continued From page 56 care of him. She said she did remember seeing it on his dresser and that is why she signed it off on 05/21/18 at 12:33 as on his hand (device in place). She said she did not remember putting the palm guard on Resident #9 on 05/21/18. In an interview with the Assistant Director of Nursing on 05/25/18 at 9:25 AM he stated that if the nurse aide replied "yes" to device in place in POC that it meant that the device (palm guard) was on the resident at the time it was signed off. Review of the electronic Kardex in POC revealed that both Nurse Aide #9 and #10 replied "yes" to device in place on 05/21/18 for Resident #9's palm guard.	F 842		