STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	06/07/2018

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HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to assess the ability of a resident to self-administer oral medications (Rolaids and Tums) that he kept at the bedside for 1 of 2 residents (Resident #239) reviewed for self-administration of medications. Findings Included: Resident #239 was admitted to the facility on 5/21/18. Diagnoses included fractured neck of femur, end stage renal disease, pressure ulcer left heel, sleep apnea, muscle weakness and malignant neoplasm of prostrate. Review of the Admission Nursing Assessment/ Screening form dated 5/21/2018 revealed that Resident #239 was cognitively intact. Resident #239 had adequate vision and hearing. Resident #239 was not assessed to self-administer medications or keep medications at the bedside. Review of the care plans dated 5/25/2018 revealed that Resident #239 was not care planned to self-administer medications.	F 554	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F554 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility staff nurses failed to identify that the patient had over-the-counter medications at beside and did not follow policy on Self Administration of Medications at bedside. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. All patient rooms were checked for medications (prescription or over-the-counter), to ensure that no other medications were	7/5/18

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

Electronically Signed | 06/25/2018

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F 554	Continued From page 1 Review of the admission Minimum Data Set (MDS) dated 5/28/2018 revealed that the assessment was still in progress. An observation on 6/4/2018 at 3:23pm revealed an open container of Tums on the bedside table of Resident #239. An observation and interview with Resident #239 on 6/5/2018 at 4:15pm revealed a bottle of Rolaids and Tums on the bedside table. Resident #239 stated that he used the medications for indigestion, upset stomach or gas as symptoms occurred. Review of the physician orders on 6/05/18 4:25 PM revealed no order for Resident #239 to self-administer medications or keep medications at the bedside. An interview with the Unit Manager (UM) on 6/6/2018 at 8:59am revealed that she was not aware that the medications were at the bedside. An observation with the UM revealed that Resident #239 did not have an order to self-administer medication in the electronic record. The UM verbalized that Resident #239 had not been assessed to self-administer medication. The UM explained that residents that self-administer medications have to be assessed, perform return demonstration, a physician order had to be obtained for self-administration & to keep medication at the bedside, and a lock box provided for storage.	F 554	found at bedside. When a medication during the initial audit, were, identified they were removed from the patients room until determination by the Interdepartmental Team and could evaluate the abilities of the resident to safely administer medication. A patient with a BIMS score of 12 or less will not, be considered for self-administration due to patients inconsistent cognitive function. Nurses, CNAs and Therapy staff were educated on Nursing Policy 1805, Self-Administration of Medication at bedside and making sure that attention is payed to items in resident rooms when providing care. Location of policies and availability will continue to be educated during orientation for staff. CNAs and Therapy staff were educated to notify the charge nurse of any medications seen at bedside. Immediately, and the nurse will remove and report to the DON/Administrator, so that appropriate steps could be taken to properly determine the patients ability to safely administer medications and properly secured the medications in a lock box if determination is made by the IDT that the patient can safely administer the medications. A, letter was drafted to families and patients outlining the necessity for patients and families to notify the facility of medications that are brought into the facility. Patients and families during the admission process will be, given, a letter explaining the self-administration process. This will also provide families with education in this process, effective July 5, 2018 forward.	

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F 554	Continued From page 2 An interview with the Director of Nursing on 6/6/2018 at 3:27pm revealed that he expected for the resident to be assessed, a physician order obtained and the care plan to be developed after the resident has been assessed to self-administer medications. An interview with the Administrator on 6/6/2018 at 3:54pm revealed that her expectation regarding self-administration of medication would be that once the medication was discovered, the resident would be assessed, a physician order obtained and a care plan developed.	F 554	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The charge nurse is responsible for the medication cart and the assigned rooms for that cart will be responsible to check each patient□s room daily to ensure no medications are at bedside for a period of 3 months. The DON, SDC or Unit Coordinator/Manager will do visualization of each patient□s room weekly for a period of 3 months, observing for medications at bedside. These audits will be completed and provided to the QAPI committee for review quarterly and reviewed during weekly risk to ensure continued compliance. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be responsible to ensure compliance with the Plan of Correction.	
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565		7/5/18

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F 565	Continued From page 3 the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to respond to concerns of the resident council for 2 of 2 consecutive resident council meetings held on April 24, 2018 and May 30, 2018. The findings included: Review of resident council minutes dated 04/24/18 revealed the resident council asked for additional staff during meal times to assist with beverage refills and other meal requests.	F 565	F565 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The Director of Nursing failed to return to the resident council group and report resolution to a concern brought up during Resident Council. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. Activities	

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F 565	Continued From page 4 Review of resident council minutes dated 05/30/18 revealed no documentation of a response to the request regarding dining service. The minutes documented "update on going resolutions and changes" without specification of the concerns. During a group interview on 06/05/18 at 2:11 PM, Residents #12, #15, #33, and #35 reported dining service continued to be a problem with delay in beverage service, item requests and assistance with departure from the dining room. Interview with Resident #15, resident council president, on 06/05/18 at 2:35 PM revealed the resident council did not receive a response to the dining service concerns. Resident #15 explained the group voiced the concern "several months ago." Interview with the activity director (AD) on 06/06/18 at 8:53 AM revealed the resident council's concern with dining service was documented and forwarded to the Director of Nursing (DON). The AD reported the resident council did not receive a response. Interview with the DON on 06/06/18 at 8:58 AM revealed he was aware of the resident council's concern with dining service. The DON reported he did not respond to the resident council concerns formally but thought the dining service concern was resolved. The DON could not provide the documented concern forwarded by the AD. Interview with the Administrator on 06/06/18 at 9:07 AM revealed the resident council should	F 565	Director will document Council concerns/problems in Resident Council Minutes. Individual concerns, will be addressed on the Service Concern Report form and turned into the Administrator upon completion of the Resident Council. The Administrator will be, immediately informed of any urgent issues, council concerns, or problems. During the subsequent Activities Director□s Weekly Meeting with the Administrator, the Activities Director will validate completion of both the Resident Council Minutes form and the corresponding Administrative Response to Resident Council form with administrator□s signature. The Activities Director or designated person will then present back to the Resident Council the resolutions to the previous meeting. The Administrator and DON may attend if invited by the resident council to address the facility responses. The Administrator, Assistant Administrator and Activities Director were educated by Nurse Consultant, on the, Activities Policy #601, Resident Council on June 7, 2018. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. A copy of the completed Resident Council Meeting Minutes and any concerns. The results of the meetings will be maintained by the Administrator, and signed off, for compliance and available in the Plan of Correction Book for a period of 4 months. If the Administrator, finds that concerns	

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F 565	Continued From page 5 receive a response to concerns.	F 565	have not been addressed and resolutions presented back to the Resident Council in a written format to prove that it was accomplished, the designated person responsible to have delivered the information will receive disciplinary action. The title of the person responsible for implementing the acceptable plan of correction. The Activities Director will be responsible to ensure compliance with the Plan of Correction.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 577		7/5/18

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F 577	Continued From page 6 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to have the results of the surveys conducted after the prior recertification survey available for residents and visitors to review. The findings included: Observations on 06/04/18 at 9:00 AM, 06/05/18 at 1:51 PM and on 06/06/18 at 9:09 AM revealed a framed sign placed on a table upon entry to the facility. The message on the sign included: "Survey Results Location. Please find the results of our most recent survey in the Survey Results binder below." There were no available survey results below the sign or on the table. Observation on 06/06/18 at 9:11 AM revealed the survey results binder was located at the end of the receptionist counter against the wall behind a hand sanitizer stand. Review of the survey results binder contents revealed the most recent survey result available was the recertification and complaint investigation survey conducted on 08/24/17. Review of the state agency database revealed the state agency conducted a revisit survey on 10/12/17, complaint investigation surveys on 01/22/18 and 04/05/18, and a follow up complaint survey with a complaint investigation survey on 05/17/18. Interview with the Administrator on 06/06/18 at	F 577	F577 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The Administrator failed to have survey results easily accessible to anyone that wanted to review the results. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. At the time of the deficiency when being identified, the Administrator immediately placed the missing survey results in the book. The Nurse Consultant made new signage and placed a sign on the receptionist desk denoting location of the survey book and another sign was developed, and placed below the counter top underneath the book. This allows handicap accessibility for wheelchair bound visitors/patients, to be readily identifiable of the location of the Survey Results Book. Education will not, be given to the Administrator as the Administrator was clearly aware of the requirement and knew it was her responsibility and took ownership of the oversight. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. Upon return of any, survey	

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F 577	Continued From page 7 9:14 AM revealed she was responsible to keep the binder current. The Administrator reported the survey results binder should contain the most recent surveys.	F 577	results, the administrator will post and sign an audit tool verifying the placement and place with the Plan of Correction, to indicate compliance. The title of the person responsible for implementing the acceptable plan of correction. The Activities Director will be responsible to ensure compliance with the Plan of Correction. The Administrator or Assistant Administrator will be responsible to ensure compliance with the Plan of Correction.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		7/5/18

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F 636	Continued From page 8 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to conduct a comprehensive	F 636	F636 The plan of correcting the specific	

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F 636	Continued From page 9 assessment to identify and analyze how condition affected function and quality of life related to falls for 1 of 10 sampled residents who required assessments of fall risk (Resident #67). The findings included: Resident #67 was admitted to the facility on 04/16/18 with diagnoses which included recent fracture of the right neck of the femur, repeated falls, glaucoma, and dementia. Review of Resident #67's hospital discharge summary dated 04/16/18 revealed Resident #67 fell prior to hospitalization which resulted in a fracture. Review of Resident #67's admission Minimum Data Set (MDS) dated 04/23/18 revealed an assessment of severely impaired cognition with physical behavior directed toward others in the past 1 to 3 days. The MDS indicated Resident #67 required the extensive assistance of two persons with transfers and inability to determine fall history prior to admission. The MDS triggered the Fall Care Area Assessment (CAA). Review of Resident 67's Falls CAA dated 05/17/18 revealed no documentation of findings with a description of the problem, contributing factors, and risk factors related to falls. The CAA did not describe or analyze Resident #67's fall prior to admission. The was no documentation of input from Resident #67's family and/or representative. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with MDS Coordinator #1 on 06/06/18 at	F 636	deficiency. The plan should address the processes that led to the deficiency cited. The Minimum Data Set Coordinator failed to give a thorough investigation to the cause of a fall while at home prior to admission and failed to contact family and/or representative to perform an analysis and determine the need to proceed to care plan. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On June 7, 2018, the MDSC Consultant provided education to the MDSC regarding the RAI Rules for completion of Fall CAA to analyze the findings with a description of the problem, contributing factors, and risk factors related to falls. MDS Coordinator and/or MDSC Consultant will conduct an audit of all current residents□ recent comprehensive MDS to ensure the triggered fall CAA included an analyze of the findings with documentation the findings with a description of the problem, contributing factors, and risk factors related to falls. The audit by te MDS Coordinator and/or MDSC Consultant will be completed by July 5, 2018. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Consultant or designee will audit five residents□ completed Comprehensive MDS to	

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F 636	Continued From page 10 9:47 AM revealed she did not realize Resident #67's fall CAA did not contain documented descriptions, contributing factors, risk factors and analysis of findings. Interview with the Administrator on 06/06/18 at 10:39 AM revealed she expected the MDS Coordinator to follow the Resident Assessment Instrument process. The Administrator reported CAAs should contain documentation of descriptions, contributing factors, risk factors and analysis of findings.	F 636	ensure the triggered fall CAA included an analysis of the findings with documentation of a description of the problem, contributing factors, and risk factors related to falls. The audits will be, completed, one time a week for 1 month, twice a month for 1 month and monthly for ten months. Any coding issue identified during the audits, will be, immediately corrected, with coaching/discipline as needed to the MDS. The Audits are to be presented, at the Quality Assurance Performance Improvement Committee (QAPI) meeting for a period of two months. The title of the person responsible for implementing the acceptable plan of correction. MDSC Consultant will be responsible for ensuring the Plan of Correction is implemented and audits completed and presented to QA/Risk as listed.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurate code the Minimum Data Set (MDS) related to falls for 1 of 1 sampled residents who fell prior to admission (Resident #67). The findings included:	F 641	F641 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. Facility failed to, accurately code the MDS assessment related to fall prior to admission for Resident #67. On 6/6/18,	7/5/18

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F 641	Continued From page 11 Resident #67 was admitted to the facility on 04/16/18 with diagnoses which included recent fracture of the right neck of the femur, repeated falls, glaucoma, and dementia. Review of Resident #67's hospital discharge summary dated 04/16/18 revealed Resident #67 fell prior to hospitalization which resulted in a fracture. Review of Resident #67's admission Minimum Data Set (MDS) dated 04/23/18 revealed an assessment of severely impaired cognition with physical behavior directed toward others in the past 1 to 3 days. The MDS indicated Resident #67 required the extensive assistance of two persons with transfers and inability to determine fall history prior to admission. Interview with MDS Coordinator #1 on 06/06/18 at 1:55 PM revealed the omission of Resident #67's fall history was an oversight. MDS Coordinator #1 reported the MDS should be coded as fall prior to admission. Interview with the Administrator on 06/06/18 at 2:13 PM revealed she expected the MDS to be accurate.	F 641	MDSC modified Resident #67 4/23/18 Admission MDS, to accurately code fall prior to Admission. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. On June 7, 2018, the MDSC Consultant provided education to the MDSC regarding the RAI Rules for coding Question J1700 Fall History on Admission/Entry or Reentry. The MDS Coordinator and/or MDSC Consultant will conduct an audit of all current residents□, Admission MDS or first MDS, completed since most recent entry to ensure, Question J1700, Fall History on Admission/Entry or Reentry is coded correctly. The audit is to be, completed, by July 5, 2018. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The MDS Consultant or designee will audit five residents□, Admission MDS or first MDS completed since most recent entry to ensure Question J1700, Fall History on Admission/Entry or Reentry, ensuring the MDS is correctly coded. This will be accomplished, one time a week for 1 month, twice a month for 1 month and monthly for one month. Any coding issue identified, on the audits, will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during	

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F 641	Continued From page 12	F 641	the Quality Assurance meeting for 1 month. The title of the person responsible for implementing the acceptable plan of correction. MDSC Consultant will be responsible for ensuring the Plan of Correction is implemented and audits completed and presented to QA/Risk as listed.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in August, 2017. These were for deficiencies cited during the facility ' s recertification and complaint investigation survey conducted on 08/24/17. The deficiencies were in the areas of comprehensive assessments and infection control. The continued failure of the facility to sustain compliance, during two federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included:	F 867	F867 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. Facility failed to identify areas of incompleteness on Comprehensive Assessments and Infection Control during the monitoring of previous deficiencies. F636- The Minimum Data Set Coordinator failed to give a thorough investigation to the cause of a fall while at home prior to admission and failed to contact family and/or representative to perform an analysis and determine the need to proceed to care plan. F880 - Nurse #1 failed to follow injection administration	7/5/18

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F 867	Continued From page 13 This tag is cross referred to: F 636: Comprehensive Assessments. Based on staff interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to falls for 1 of 10 sampled residents who required assessments of fall risk (Resident #67). The facility was recited for F 636 for failure to conduct a comprehensive assessment related to falls. The facility was originally cited during a recertification and complaint investigation survey on 08/24/17 for failure to conduct a comprehensive assessment related to nutrition. F 880: Infection control. Based on observations, staff interviews, and policy review, the facility failed to wear gloves during the administration of insulin for 1 of 1 residents (Resident #7) resulting in a possible staff member exposure to a bloodborne pathogen. The facility was recited for F 880 for failure to use gloves during an insulin injection. The facility was originally cited during a recertification and complaint investigation survey on 08/24/17 for failure to disinfect a blood glucose meter and adherence to isolation procedures. Interview with the Administrator on 06/07/18 at 10:41 AM revealed the facility's quality assurance committee monitored comprehensive assessments and infection control procedures. The Administrator reported the facility conducted medication pass observations on a regular basis which included insulin administration. Comprehensive assessments received oversight	F 867	policy, and don gloves, when administering an insulin injection. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. F-636On June 7, 2018, the MDSC Consultant provided education to the MDSC regarding the RAI Rules for completion of Fall CAA to analyze the findings with a description of the problem, contributing factors, and risk factors related to falls. MDS Coordinator and/or MDSC Consultant will conduct an audit of all current residents recent comprehensive MDS to ensure the triggered fall CAA included an analyze of the findings with documentation the findings with a description of the problem, contributing factors, and risk factors related to falls. The audit by MDS will be completed by July 5, 2018 and F880 - All staff nurses will be in-serviced on Infection control during medication administration and training completed by July 5, 2018, any nurse not receiving the education will be removed from the staffing schedule until the education is completed. During orientation Staff Nurses will be provided education and a copy of documents for procedures to administer medications, areas covered are 1) Subcutaneous Injections, 2) Intramuscular Injections, 3) Opthalamic Drops, 4) Orally Inhaled Medications, 5) Topical Medications, 6) Transderm Medications, 7) Otic Drops, 8) Buccal and Sublingual Medications, 9) Nasal Medications, 10) Rectal	

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F 867	Continued From page 14 from the facility's Minimum Data Set consultant. The Administrator reported the facility did not identify any concerns.	F 867	Suppositories, 11) Vaginal Medications, 12) Enteral Medications. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. F-636 - The MDS Consultant or designee will audit 5 residents□ completed Comprehensive MDS to ensure the triggered fall CAA included an analyze of the findings with documentation of a description of the problem, contributing factors, and risk factors related to falls. These audits will be, accomplished, one time a week for 1 month, twice a month for 1 month and monthly for one month. Any coding issue identified on the audits will be, immediately corrected, with coaching/discipline as needed to the MDS. The results of the audits will be presented, to the Quality Assurance Performance Improvement Committee, for 10 months. F880 □ The DON or Staff Development Coordinator, will perform one med pass observation on each medication cart every week for 4 weeks, perform one med pass observation on every cart every other week x4, then one med pass observation on each cart monthly x9, utilizing Medication Pass Observation Forms. There will be no repeat observations of any nurse until all nurses have been observed once, only then will a repeat observation be performed if needed to fulfill the audit requirements through its end date for	

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F 867	Continued From page 15	F 867	Medication Pass Observation. The Medication Pass Observations result will be discussed, during the weekly Risk Meeting. The title of the person responsible for implementing the acceptable plan of correction. F-636 - MDSC Consultant will be responsible for ensuring the Plan of Correction is implemented and audits completed and presented to QA/Risk as listed and F880 - The Director of Nursing will be responsible to ensure compliance with the Plan of Correction.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		7/5/18

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F 880	Continued From page 16 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 17 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and policy review, the facility failed to wear gloves during the administration of insulin for 1 of 1 residents (Resident #7) resulting in a possible staff member exposure to a bloodborne pathogen. The findings included: A review of a facility policy titled, "Subcutaneous Injections" undated, read in part, Step 2. Identify Resident- Explain procedure. Step 3. Wash hands. Wear gloves. A review of the most recent Minimum Data Set (MDS) assessment dated 5/3/18 for Resident #7 was coded with diagnoses including diabetes and dementia. On 6/05/18 at 11:50am, Nurse #1 was observed during an insulin (a medication used to manage diabetes) administration not wearing gloves while providing the subcutaneous injection. During an interview on 6/05/18 at 11:52am, Nurse #1 confirmed she had not worn gloves during the insulin administration for Resident #7 and indicated she usually wears gloves but was nervous during the observation with the surveyor. An interview on 6/6/18 at 1:53pm was conducted with the Administrator. During this interview the Administrator stated nurses should wear gloves	F 880	F880 The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. Nurse #1 failed to follow injection administration policy and don gloves when administering an insulin injection. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. All staff nurses will be in-serviced on Infection control during medication administration and training will be completed by July 5, 2018, any nurse not receiving the education will be removed from the staffing schedule until the education is completed. During orientation Staff Nurses will be provided education and a copy of documents for procedures to administer medications, areas covered are 1) Subcutaneous Injections, 2) Intramuscular Injections, 3) Opthalamic Drops, 4) Orally Inhaled Medications, 5) Topical Medications, 6) Transderm Medications, 7) Otic Drops, 8) Buccal and Sublingual Medications, 9) Nasal Medications, 10) Rectal Suppositories, 11) Vaginal Medications, 12) Enteral Medications. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 880	Continued From page 18 during the administration of insulin for prevention of exposure and transmission of bloodborne pathogens. An interview on 6/06/18 at 1:56pm with the Director of Nursing (DON) revealed the Infection Control Preventionist (ICP)/Staff Development Coordinator(SDC) was on vacation and the DON was covering this role. The DON stated his expectation was for nurses to follow training they were provided which included, washing hands and wearing gloves prior to the administration of subcutaneous medications.	F 880	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The DON or Staff Development Coordinator will perform one med pass observation on each medication cart every week for 4 weeks, perform one med pass observation on every cart every other week x4, then one med pass observation on each cart monthly x9, utilizing Medication Pass Observation Forms. There will be no repeat observations of any nurse until all nurses have been observed once, only then will a repeat observation be performed if needed to fulfill the audit requirements through its end date for Medication Pass Observation. The Medication Pass Observations will be discussed, during the weekly Risk Meeting. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be responsible to ensure compliance with the Plan of Correction.	