STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 02/18/2019 through 02/22/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 9ZO511.	E 000		
F 565 SS=E	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 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.	F 565		3/22/19

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

Electronically Signed | 03/15/2019

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F 565	Continued From page 1 §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 Council Minutes, resident interviews and staff interviews the facility failed to make prompt efforts to resolve grievances concerning not enough staff and staff being disrespectful, no ice passed on first and second shift and not getting baths on third shift, that were reported to staff in Resident Council Meetings for three of seven residents who previously voiced grievances in Resident Council Meetings. (Resident #33, Resident #94 and Resident #142). The findings included: Review of Resident Council Minutes from December, 2018 through February, 2019 revealed grievances such as not enough aides and aides being disrespectful had not been responded to for three meetings, no ice water passed on first shift had not been responded to for three meetings and not getting baths on third shift had not been responded to for two meetings. During a Resident Council Meeting held on 2/19/19 at 11:00 AM, Resident #33 said he was not getting a bath on third shift and it happened often. Resident #33, Resident #142 and Resident #94 revealed there were not enough aides and aides were being disrespectful. Resident #94 and Resident #142 revealed response to call lights was thirty minutes to one hour for someone to respond and then the staff person would turn out the light and say they would be back. Resident	F 565	Willow Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Willow Creek Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 565 Resident/ Family Group and Response On 3/13/19, the Resident Liaison interviewed Resident #33 and discussed the concern related to not receiving a bath on third shift to ensure concerns were resolved. Resident #33 stated the	

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#142 and Resident #94 revealed there were not enough staff on the halls to provide care. Resident #94 and Resident #33 revealed they were supposed to get baths on third shift and sometimes they had to wait until the next morning to get a bath.

During an interview on 2/20/19 at 4:18 PM, the facility Activity Director said the Resident Liaison was usually in the meetings to get all of the resident group concerns. The Activity Director said the Activity Assistant would sometimes takes notes for the meeting and the Resident Liaison would follow-up on the concerns. She said the Resident Liaison was at the Resident Council Meeting in December, but she did not attend the meeting in January and February because she was on leave of absence. The Activity Director stated she had not heard anything about staff being disrespectful to residents and not having enough staff.

During an interview on 2/21/19 at 1:49 PM the Resident Liaison said depending on the nature of the concern she would personally follow up on them. She said she would follow up on the concerns about no ice water as she was walking the building. She stated she never got some of the grievances so she was not able to follow up on them. She said she had been out on leave of absence.

During an interview on 2/21/19 at 3:44 PM, the facility Social Worker, SW#2 stated she immediately addressed grievances and forwarded them to the Director of Nursing and Administrator. She stated she did not recall any descriptions of residents being verbally or physically abused. She stated she had done inservices on how to treat

concerns had been addressed. On 3/13/19, the Resident Liaison interviewed Resident # 142 and Resident # 94 regarding not enough aids, aids being disrespectful, call light response, not enough staff on the halls to provide care and receiving baths on third shift to ensure concerns were resolved. Resident #142 and resident #94 both stated that the concerns had been addressed.
On 3/14/19, the Resident Liaison reviewed all resident council meeting minutes for the past 4 months from November 2018- February 2019 to include not enough aids, aids being disrespectful, call light response, not enough staff of the halls to provide care and receiving baths on third shift to. This audit was to ensure the facility resolved grievances voiced in the resident council meeting. Any identified areas of concern or grievances that were not resolved were written on a grievance form and investigated and resolutions by the Resident Liaison by 3/15/19.
On 2/21/19, the Administrator initiated an in-service for the Activity Coordinator, Resident Liaison, Director of Nursing, RN Supervisors, Maintenance, Dietary Supervisors, Therapy Manager, Social Workers, Housekeeping Supervisor, and Business Office Manager (Department Managers) on Resident Council Meeting and voiced concerns, which included: 1) 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

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F 565	Continued From page 3 residents with dignity and respect. During an interview with the Administrator and Director of Nursing (DON) on 2/22/19 at 9:53 AM, the Administrator revealed his expectation was to have the resident grievance forms completed for Resident Council Meetings and the grievances should be followed up per grievance policy.	F 565	in the facility. 2) When there are resident council minutes or interviews that residents voice concerns or grievances, the grievance should be written on a resident council concern form and given to the Resident Liaison. The Resident Liaison will ensure that the grievance is logged on the grievance log and forward the grievance to the appropriate department manager to ensure the grievance is addressed, responded to, and promptly resolved in a timely manner. 3) The resolution will be discussed and documented at the next resident council meeting. This in-service was completed on 3/15/19 by the Administrator. The Administrator and/or DON will review resident council minutes and Resident Council concerns that were voiced to include residents # 33, # 94 and #142 utilizing the Resident Council Audit Tool monthly for 3 months. This audit is to ensure that grievances have been written on a resident council grievance form and promptly resolved that were voiced during the resident council meetings. The Administrator and/or Director of Nursing will reeducate the Department Managers to ensure that all grievances are resolved promptly for areas of identified concerns. The Administrator will forward the Resident Council Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place	

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F 565	Continued From page 4	F 565	and to determine the need for further and / or frequency of monitoring.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff	F 604	F 604 Right to be Free from Physical	3/22/19

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F 604	Continued From page 5 interviews, the facility failed to provide a medical symptom for 1 of 1 sampled residents reviewed with a bed rail restraint. (Resident #60). The findings included: Resident #60 was originally admitted to the facility on 10/5/18, with diagnoses including Alzheimer's disease, Hypertension, Muscle Weakness (Generalized) and Altered Mental Status. According to the most recent Quarterly Minimum Data Set (MDS) dated 1/4/19, Resident #60 was cognitively impaired. He required extensive assistance in bed mobility and transfers. Review of Section R (restraints and alarms) on the MDS revealed Resident #60 was coded for bed rail restraints (used daily). Review of Resident #60's medical record revealed there was no doctor's order for a medical symptom for bed rail restraints. Resident #60's care plan goal dated 10/5/18, revised 2/20/19, addressed use/application of physical restraint device (side rails) for prevention of injury to self or to others characterized by high risk for injury/falls, impaired mobility and physical aggression related to cognitive impairment. Interventions included evaluate for least restrictive, reduction, and/or discontinuation per facility protocol and evaluate for underlying causes for potential behavior, falls, injury, unsteady gait and environmental barriers. The care plan goal, revised date 12/28/18, also addressed use of bed rails for increasing or maintaining current bed mobility and/or transfer ability. This goal was not revised on 2/20/19 as noted for the previous goal. Interventions	F 604	Restraints On 2/20/2019, a doctor□s order was written for Resident #60 bilateral side rails with a medical symptom for bedrail restraint by the Minimum Data Set Nurse (MDS). On 3/14/19, the MDS Coordinator reviewed 100 % of all residents to include Resident # 60 with restraints including bed rail restraints to ensure that all residents have a doctor□s order with a medical symptom for the restraint. There were no other identified areas of concern. On 3/15/19, the Director of Nursing initiated an in-service for 100% of nurses regarding: all residents must have a doctor□s order with a medical symptom for a restraint. This in-service will be completed by 3/22/19. The RN Supervisors will review 10 % of all residents to include Resident # 60 with restraints including bedrails weekly X 8 weeks then monthly X 1 month utilizing the Restraint Audit Tool. This audit is to ensure that all residents with restraints have a doctor□s order with a medical symptom for the restraint. The Director of Nursing will reeducate the nurses and obtain a clarification doctors order with a medical symptom for any identified areas of concern during the audit. The Director of Nursing will review and initial the Restraint Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were address. The Director of Nursing will forward the	

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F 604	Continued From page 6 included assess resident for risk of entrapment from bed rails periodically and as necessary. Check bed rails periodically for proper functioning, ensure bed dimensions are appropriate for resident, ensure bed rails are installed and maintained per manufacturer's recommendations, and evaluate use of the device periodically for continued effectiveness and appropriateness. Provide and review with resident and or family/representative the risks and benefits of the use of bed rails. Use of bed rails to assist resident to increase ability to enter and exit the bed at highest practicable mobility level. During an observation on 2/20/19 at 12:08 PM, Resident #60 was lying on his bed asleep in his room. His bed was lowered to the floor and a mattress was on the floor next to his bed. Half bed rails up on his bed. During an observation on 2/20/19 at 12:13 PM, Resident #60 was lying in bed, head of bed raised, bed rails up. The head of his bed was raised and the mattress removed from the floor so that the NA could assist with feeding the resident. During an interview on 2/20/19 at 2:24 PM, Nursing Assistant (NA#2), revealed Resident #60 did not try to get out of bed now. She stated he liked to let his legs hang over the bed. She said the bed rails were used to ensure he did not fall and hit the floor. She stated sometimes he would pull up and slide on the floor, but he had not recently tried to get up by himself. During an interview on 2/20/19 at 2:32 PM, NA#3 revealed the fall mattress was used to prevent	F 604	Restraint Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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Resident #60 from hitting the floor. She said she was not sure the reason the bed rails were used. She said the bed rails were always up on his bed.

During an interview on 2/20/19 at 3:55 PM, NA #1, stated Resident #60 had bed rails on his bed because he was a fall risk and had tried to get out of bed by himself.

During an interview on 2/20/19 at 4:00 PM, Staff Nurse #13 revealed Resident #60 had bed rails on his bed to keep him from rolling off the bed. She said he had not rolled or fallen out of bed while she worked.

During an interview on 2/21/19 at 8:30 AM, Staff Nurse #12 stated Resident #60 had a full mattress on the floor next to his bed because he would try to get up and had a couple of falls. She stated Resident #60's bed was kept in the lowest position when no one was in his room. She stated Resident #60 was trying to get out of bed unassisted and the mattress on the floor was an intervention. Staff Nurse #12 stated the bed rails on Resident #60's bed were used for safety, to prevent him from rolling out of bed. She stated he would throw his legs off the end of his bed. Staff Nurse #12 said the bed rails were also used for Resident #60 to pull himself up in bed or help to assist staff in positioning.

During an observation on 2/21/19 at 2:00 PM, Resident #60 was lying in bed asleep. His bed was lowered to the floor and a mattress was on the floor next to his bed. Half bed rails were up on his bed.

During an interview on 2/21/19 at 3:31 PM, the MDS Nurse #1 revealed the reason Resident #60

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F 604	Continued From page 8 was coded on his MDS for bed rail restraints was because of impaired cognition and combative behavior and he would get out of bed unassisted. When the MDS Nurse #1 was asked the reason she had not completed a bed rail assessment prior to coding the bed rails as a restraint, she revealed that was something she was trying to rectify as well as the doctor's order. During an observation on 2/22/19 at 9:30 AM, Resident #60 was lying awake in bed. A mattress was on the floor next to his bed. The resident's bed was lowered to the floor and half bed rails were up on his bed. During an interview with the Director of Nursing (DON) and Administrator on 2/22/19 at 10:00 AM, the DON revealed her expectation was to care plan restraints, have a doctor's order per diagnosis, the need for the restraint and to follow policy and protocol.	F 604		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		3/22/19

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(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 11 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the family member or responsible party in writing when 4 of 4 sampled residents (Residents # 117, 98, 87 and 135) were discharged to the hospital. The findings included: 1. Resident # 117 was admitted to the facility on 8/22/17 and readmitted on 1/9/19 with diagnoses including Acute Renal Failure, Benign Prostate Hypertrophy, Anemia, Hypertension, and Dementia. A review of Resident #117's annual Minimum Data Set (MDS) dated 1/23/198 identified him as having severely impaired cognition. A review of Resident # 117's medical record revealed he was sent to the hospital on 1/1/19 for evaluation due to increased temperature of 101.2 and renal failure. He returned to the facility on 1/9/19. No written notice of transfer was documented to have been provided to the resident or his responsible party (RP). In an interview on 2/20/19 at 2:41 PM Nurse # 5 revealed when sending a resident out to the hospital, she would send a copy of the residents profile page, MAR (medication administration record), medications and profile page. She stated she thought the business office or Social Worker would call the family to notify them of the transfer. In an interview on 2/20/19 at 4:14 PM Nurse # 4	F 623	F 623 Notice Requirements Before Transfer/Discharge On 3/14/19, written notification of the transfer/discharge to include the reason for the transfer/discharge to the hospital was provided to the Resident/ Resident Representative by the Social Worker for Residents # 117, # 98, #87, #135. 100% audit of current residents transfer/discharges x 30 days to include Resident # 117, # 98, # 87, #135 was completed by the Social Worker to ensure resident and/or resident representative received written notification of the transfer/discharge to include the reason for the transfer/discharge when transferred to the hospital/discharge from the facility. During the audit, all areas of concern were addressed by the Social Worker by providing written notification of the policy on 3/14/19 by certified mail. On 2/21/19, an in-service was initiated with all social workers by the Administrator regarding providing written notification to the Resident/ Resident Representative for the Notice of Transfer/Discharge before/upon hospital transfer with documentation in the clinical record. All newly hired social workers will receive the in-service upon hire in orientation. The in-service will be completed by 3/22/19. 10% audit of current residents transfers/discharges will be completed by	

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F 623	Continued From page 12 revealed she would send a copy of the residents' MAR (medication administration record), their code status, a copy of their face sheet and the progress notes when sending a resident out to the hospital. In an interview on 2/21/2019 at 10:03 AM the Social Worker (SW #1) stated she did not send any notice or reason for discharge to the resident or family of resident, because the nurse on the floor would notify the family by phone. The SW stated she emailed the Ombudsman at the end of the month to notify her of facility discharges. During an interview on 2/21/2019 at 3:14 PM the Administrator stated he expected staff to complete a transfer/discharge form, which would list the reason a resident was going to the hospital. The Administrator stated he had only started at the facility a month ago and was not sure if staff were completing the form. 2. Resident #87 was originally admitted to the facility on 5/31/17, with diagnoses including Muscle Weakness (generalized), Polyneuropathy and Hypertension. According to the most recent Quarterly Minimum Data Set (MDS) dated 1/9/19, Resident #87's cognition was intact. Resident #87 was discharged to the hospital on 2/4/19 and returned to the facility on 2/7/19. During an interview on 2/18/19 at 10:50 AM, Resident #87 revealed he did not get letter notifying him of the reason he was discharged to the hospital. During an interview on 2/20/19 at 2:41 PM, Staff Nurse # 11 stated she was an agency nurse and when a resident was discharged to the hospital	F 623	the Director of Nursing weekly x 8 weeks then monthly x 1 month utilizing the Bed Hold/Transfer Discharge Audit Tools. This audit is to ensure the resident and/or resident representative received a written notification of the transfer/discharge to include the reason for the transfer/discharge before/upon hospital transfer with documentation in the clinical record. The social workers will be retrained for any identified areas of concerns during the audit. The Director of Nursing will review the Bed Hold/Transfer Discharge Audit Tools weekly x 8 weeks, and then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will forward the Bed Hold/Transfer Discharge Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 623	Continued From page 13	F 623		

she notified the resident's family by phone, but she did not send anything written to the family or resident about the reason the resident was discharged to the hospital.

During an interview on 2/21/19 at 8:30 AM, Staff Nurse # 12 revealed Resident #87 was sent to the hospital for a urinalysis because he had a urinary tract infection. She stated when a resident was discharged to the hospital, she notified the family by phone, but she did not send anything written to the family or resident about the reason the resident was discharged to the hospital.

On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated she did not send any notice or reason for discharge to the resident or family of resident, because the nurse on the floor would notify the family by phone. The SW stated she emailed the Ombudsman at the end of the month to notify her of facility discharges.

During an interview on 2/21/19 at 3:14 PM, the Administrator stated he expected staff to send the face sheet, medications and a transfer/discharge form which would list the reason a resident was going to the hospital and a copy of the bed hold policy. The Administrator stated he had only started at the facility a month ago and was not sure if staff were completing the form.

3. Resident #98 was originally admitted to the facility on 2/7/18, with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes without complications and Chronic Atrial Fibrillation. According to the most recent Quarterly Minimum Data Set (MDS)

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dated 1/17/19, Resident #98's cognition was intact.

Resident #98 was discharged to the hospital on 12/18/18 and returned to the facility on 12/21/18. The resident was also discharged to the hospital on 1/3/19 and returned to the facility on 1/6/19.

During an interview on 2/18/19 at 3:45 PM, Resident #98 she did not get any written information from the facility about the reason she was discharged to the hospital.

During an interview on 2/20/19 at 2:41 PM, Staff Nurse # 11 stated she was an agency nurse and when a resident was discharged to the hospital she notified the resident's family by phone, but she did not send anything written to the family or resident about the reason the resident was discharged to the hospital.

During an interview on 2/21/19 at 8:30 AM, Staff Nurse # 12 revealed Resident #98 was sent to the hospital because her shunt (for dialysis) was not working. She stated when a resident was discharged to the hospital, she notified the family by phone, but she did not send anything written to the family or resident about the reason the resident was discharged to the hospital.

On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated she did not send any notice or reason for discharge to the resident or family of resident, because the nurse on the floor would notify the family by phone. The SW stated she emailed the Ombudsman at the end of the month to notify her of facility discharges.

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During an interview on 2/21/19 at 3:14 PM, the Administrator stated he expected staff to send the face sheet, medications and a transfer/discharge form which would list the reason a resident was going to the hospital and a copy of the bed hold policy. The Administrator stated he had only started at the facility a month ago and was not sure if staff were completing the form.

4. Resident #135 was admitted to the facility on 12/3/2014 with diagnoses to include gastrointestinal hemorrhage, chronic kidney disease, and hydronephrosis.

Resident #135 was discharged to the hospital on 9/28/2018 and re-admitted to the facility on 10/2/2018; was discharged to the hospital on 11/30/2018 and re-admitted to the facility on 12/3/2018; and discharged to the hospital on 1/11/2019 and re-admitted to the facility on 1/19/2019.

Resident #135's annual Minimum Data Set (MDS) assessment dated 1/26/2019 revealed her cognition was intact, with unclear speech. The resident was unable to be interviewed.

A review of Resident #135's medical record revealed there was no indication the resident's family was provided written notification for the reason for the resident's transfer to the hospital on 9/29/2018, 11/30/2018 or 1/11/2019.

On 2/20/2019 at 10:18 AM, an interview was conducted with Nurse #2. Nurse #2 stated she had sent Resident #135 to the hospital in the past, and it was the nurse's responsibility to call the family and update them with a reason for the hospital discharge, she did not send out anything in writing.

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F 623	Continued From page 16 On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated she did not send any notice or reason for discharge to the resident or family of resident, because the nurse on the floor would notify the family by phone. The SW stated she emailed the Ombudsman at the end of the month to notify her of facility discharges. On 2/21/2019 at 3:14 PM, an interview was conducted with the Administrator, who stated he expected staff to complete a transfer/discharge form, which would list the reason a resident was going to the hospital. The Administrator stated he had only started at the facility a month ago and was not sure if staff were completing the form.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		3/22/19

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F 625	Continued From page 17 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to provide the resident or resident representative a bed hold policy when transfer to the hospital was necessary for 4 of 4 residents (Resident #117, #87, #98 and #135) reviewed for hospitalization. The findings included: 1. Resident # 117 was admitted to the facility on 8/22/17 and readmitted on 1/9/19 with diagnoses including Acute Renal Failure, Benign Prostate Hypertrophy, Anemia, Hypertension, and Dementia. A review of Resident #117's annual Minimum Data Set (MDS) dated 1/23/198 identified him as having severely impaired cognition. A review of Resident # 117's medical record revealed he was sent to the hospital on 1/1/19 for evaluation due to increased temperature of 101.2 and renal failure. He was readmitted to the facility on 1/9/19. During an interview on 2/21/2019 at 10:03 AM the Social Worker (SW) #1 stated the business office	F 625	F 625 Notice of Bed Hold Policy Before/Upon Transfer On 3/14/19 written notification of the bed hold policy was provided to the Resident/ Resident Representative by the Social Worker for Residents # 117, # 98, #87, #135. 100% audit of current residents transfer/discharges x 30 days to include Resident # 117, # 98, # 87, #135 was completed by the Social Worker to ensure resident and/or resident representative received written notification of the bed hold policy when transferred to the hospital/discharge from the facility. During the audit, all areas of concern were addressed by the Social Worker by providing written notification of the policy on 3/14/19 by certified mail. On 2/21/19, an in-service was initiated with all nurses and social workers by the Administrator regarding providing written notification to the Resident/ Resident Representative for the Bed Hold Policy Before/Upon Hospital transfer with	

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F 625	Continued From page 18 was sending out the bed hold policy after they spoke with the family. In an interview on 2/21/2/19 at 3:14 PM the Business Office Manager (BOM) stated after a resident was discharged to the hospital, the family was called to see if they wanted to hold a bed. The BOM stated she had no idea if the nurses were sending the bed hold policy with a resident when they were discharged to the hospital. During an interview on 2/21/2019 at 3:14 PM the Administrator stated he expected staff to complete a transfer/discharge form and send a bed hold policy with a resident when discharged to the hospital. 2. Resident #87 was originally admitted to the facility on 5/31/17, with diagnoses including Muscle Weakness (generalized), Polyneuropathy and Hypertension. According to the most recent Quarterly Minimum Data Set (MDS) dated 1/9/19, Resident #87's cognition was intact. Resident #87 was discharged to the hospital on 2/4/19 and returned to the facility on 2/7/19. During an interview on 2/18/19 at 10:50 AM, Resident #87 revealed he did not get a bed hold policy when he was discharged to the hospital. During an interview on 2/20/19 at 2:41 PM, Staff Nurse #11 stated she was an agency nurse and when a resident was discharged to the hospital she would send a DNR (do not resuscitate order) demograhic sheet, a copy of the medication administration record (mar) to the hospital with the resident. She said she did not know about sending a bed hold policy to the hospital with the	F 625	documentation in the clinical record. All newly hired staff nurses or social workers will receive the in-service upon hire in orientation. The in-service will be completed by 3/22/19. 10% audit of current residents transfers/discharges will be completed by the Director of Nursing weekly x 8 weeks then monthly x 1 month utilizing the Bed Hold/Transfer Discharge Audit Tools. This audit is to ensure the resident and/or resident representative received a written notification of the bed hold policy before/upon hospital transfer with documentation in the clinical record. The nurse and/or the social worker will be retrained for any identified areas of concerns during the audit. The Director of Nursing will review the Bed Hold/Transfer Discharge Audit Tools weekly x 8 weeks, and then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Director of Nursing will forward the Bed Hold/Transfer Discharge Audit Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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resident. She revealed she would call the family and inform them.

During an interview on 2/21/19 at 8:30 AM, Staff Nurse #12 revealed Resident #87 was sent to the hospital for a urinalysis because he had a urinary tract infection. She stated when a resident was discharged to the hospital, she would send a copy of the medication administration record (mar), face sheet, recent orders or labs, and doctor's orders to send the resident to the hospital emergency room. She revealed she did not know about sending the bed hold policy to the hospital with the resident. Staff Nurse #12 said if a resident was discharged to the hospital, the business office would contact the family and ask if they want a bed hold. She stated she would notify the family and the doctor, if the doctor was not the one that sent the resident to the hospital.

On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated the business office was sending out the bed hold policy after they spoke with the family.

On 2/21/2/19 at 3:14 PM, an interview was conducted with the Business Office Manager (BOM) who stated after a resident was discharged to the hospital, the family was called to see if they wanted to hold a bed. The BOM stated she had no idea if the nurses were sending the bed hold policy with a resident when they were discharged to the hospital.

On 2/21/2019 at 3:14 PM, an interview was conducted with the Administrator, who stated he expected staff to complete a transfer/discharge form and send a bed hold policy with a resident when discharged to the hospital.

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3. Resident #98 was originally admitted to the facility on 2/7/18, with diagnoses including Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes without complications and Chronic Atrial Fibrillation. According to the most recent Quarterly Minimum Data Set (MDS) dated 1/17/19, Resident #98's cognition was intact.

Resident #98 was discharged to the hospital on 12/18/18 and returned to the facility on 12/21/18. The resident was also discharged to the hospital on 1/3/19 and returned to the facility on 1/6/19.

During an interview on 2/18/19 at 3:45 PM, Resident #98 revealed she did not get was behold policy when she was discharged to the hospital.

During an interview on 2/20/19 at 2:41 PM, Staff Nurse #11 stated she was an agency nurse and when a resident was discharged to the hospital she would send a DNR (do not resuscitate order) demograhic sheet, a copy of the medication administration record (mar) to the hospital with the resident. She said she did not know about sending a bed hold policy to the hospital with the resident.

During an interview on 2/21/19 at 8:30 AM, Staff Nurse #12 revealed Resident #98 was sent to the hospital both times because her shunt, used for dialysis, was not working. She stated when a resident was discharged to the hospital, she would send a copy of the medication administration record (mar), face sheet, recent orders or labs, and doctor's orders to send the resident to the hospital emergency room. She

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revealed she did not know about sending the bed hold policy to the hospital with the resident. Staff Nurse #12 said if a resident was discharged to the hospital, the business office would contact the family and ask if they wanted a bed hold.

On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated the business office was sending out the bed hold policy after they spoke with the family.

On 2/21/2/19 at 3:14 PM, an interview was conducted with the Business Office Manager (BOM) who stated after a resident was discharged to the hospital, the family was called to see if they wanted to hold a bed. The BOM stated she had no idea if the nurses were sending the bed hold policy with a resident when they were discharged to the hospital.

On 2/21/2019 at 3:14 PM, an interview was conducted with the Administrator, who stated he expected staff to complete a transfer/discharge form and send a bed hold policy with a resident when discharged to the hospital.

4. Resident #135 was admitted to the facility on 12/3/2014 with diagnoses to include gastrointestinal hemorrhage, chronic kidney disease, and hydronephrosis.

Resident #135 was discharged to the hospital on 9/28/2018 and re-admitted to the facility on 10/2/2018; was discharged to the hospital on 11/30/2018 and re-admitted to the facility on 12/3/2018; and was discharged to the hospital on 1/11/2019 and re-admitted to the facility on 1/19/2019.

Resident # 135 annual Minimum Data Set (MDS)

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F 625	Continued From page 22 assessment dated 1/26/2019 revealed her cognition was intact, with unclear speech. The resident was unable to be interviewed. On 2/20/2019 at 10:18 AM, an interview was conducted with Nurse #2. Nurse #2 stated when a resident was discharged to hospital she sent a demographics sheet, a copy of the Medication Administration Record (MAR), a copy of the Physician orders, and a copy of the Do Not Resuscitate (DNR) form if applicable for a resident. The nurse stated it would be up to the office staff to notify the family of a bed hold policy, as a written copy of the facility's bed hold policy was not sent to the hospital with a resident. On 2/21/2019 at 10:03 AM, an interview was conducted with the Social Worker (SW #1). SW #1 stated the business office was sending out the bed hold policy after they spoke with the family. On 2/21/2/19 at 3:14 PM, an interview was conducted with the Business Office Manager (BOM) who stated after a resident was discharged to the hospital, the family was called to see if they wanted to hold a bed. The BOM stated she had no idea if the nurses were sending the bed hold policy with a resident when they were discharged to the hospital. On 2/21/2019 at 3:14 PM, an interview was conducted with the Administrator, who stated he expected staff to complete a transfer/discharge form and send a bed hold policy with a resident when discharged to the hospital.	F 625		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		3/22/19

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	345113	A. BUILDING _____ B. WING _____	C 02/22/2019

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F 698	Continued From page 23 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide ongoing communication documentation with the hemodialysis center for 1 of 1 resident reviewed for dialysis and failed to document an assessment of the resident's status, shunt site and vital signs upon returning to the facility after dialysis (Resident #118). The findings included: Resident #118 was admitted to the facility on 1/6/19 and had a diagnosis of end stage renal disease. The resident's Care Plan dated 1/18/19 noted the resident had end stage renal disease and was at risk for complications due to hemodialysis. Dialysis Monday, Wednesday and Friday. Assess resident upon return from dialysis treatment and notify the physician of any significant changes. Monitor access site for bleeding and/or signs of infection. The Admission Minimum Data Set (MDS) Assessment dated 1/23/19 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living except for limited assistance with eating. The MDS noted the resident received dialysis while residing in the facility. Review of the progress notes revealed a post dialysis assessment was documented on 1/25/19	F 698	F698 Dialysis After returning from Dialysis, resident # 118 will receive an assessment of the resident□s status, shunt site, and vital signs with documentation in the clinical record by the hall nurse by 3/22/19. A communication tool will be sent with resident # 118 to dialysis by the hall nurse by 3/22/19 to allow for communication between the facility and dialysis center. 100% audit of the progress notes for the past 30 days will be completed by 3/22/19 by the Quality Improvement (QI) Nurse for all residents receiving dialysis to include resident #118, to ensure that residents received an assessment of the resident□s status, shunt site, and vital signs upon return from dialysis. Any identified areas of concerns will be addressed during the audit by the QI Nurse. The Director of Nursing will devised a communication tool by 3/22/19 for the communication between the facility and the dialysis center. 100% in-service was initiated on 2/21/19 by the Director of Nursing for all nurses, to include nurse #1 regarding assessment of the resident□s status, shunt site, and vital signs post dialysis with documentation in	

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F 698	Continued From page 24 at 1:14 PM but no vital signs were documented in the progress notes or in the vital signs tab of the chart. Resident #118 was admitted to the hospital on 1/29/19 and treated for osteomyelitis and was re-admitted to the facility on 2/6/19. There was a post dialysis assessment documented on 2/20/19 but there were no vital signs documented. There was no other documentation of a post dialysis assessment or post dialysis vital signs found in the resident's chart. Review of the Medication Administration Record for January and February of 2019 revealed no post dialysis assessment or vital signs. On 2/19/19 at 9:22 AM Resident #118 stated during a resident interview that when she returned from dialysis the nurse would come in and check her shunt. The Resident stated she had not had any bleeding from her shunt after dialysis since admission to the facility. On 2/20/19 at 1:00 PM an interview was conducted with Nurse #1 who stated dialysis residents have a communication book that is sent with the resident to dialysis and contains a communication sheet that listed vital signs and other pertinent information for the dialysis unit. On 2/20/19 at 4:06 PM Nurse #1 stated in an interview that upon return from dialysis the nurses check the resident's shunt site for bruit and thrill and make sure there is no bleeding from the access site, take vital signs and check to make sure there have been no changes in the resident's mental status. The Nurse stated this information should be documented under the dialysis tab in the progress notes. Nurse #1 was observed to review the progress notes for Resident #118 and stated the assessment was	F 698	the clinical record; the dialysis communication tool is to be sent with each resident to dialysis to ensure effective communication between the facility and dialysis center; and review the communication tool upon residents return from dialysis for any changes. The in-service will be completed by 3/22/19. All newly hired nurses will receive the in-service upon hire in orientation by the Staff Facilitator. 10 % audit of all residents to include resident # 118 receiving dialysis treatment will be reviewed by the QI Nurse weekly x 8 weeks then monthly x 1 month utilizing the dialysis review tool. This audit is to ensure an assessment of the resident□s status, shunt site, and vital signs post dialysis is documented in the clinical record and the dialysis communication tool was completed and sent to dialysis. Any identified areas of concerns will be addressed during the audit by retraining the nurse by the QI Nurse. The Director of Nursing will review and initial the dialysis communication tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were address. The Director of Nursing will forward the Dialysis Review Tools to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or	

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F 698	Continued From page 25 not being consistently documented. On 2/20/19 at 4:48 PM an interview was conducted with the Director of Nursing (DON). The DON stated the communication sheet goes with the resident to dialysis with the resident and upon return from dialysis, the nurse would look at the sheet for any new orders or concerns during dialysis. Review of a blank communication sheet revealed a space for documentation of vital signs prior to dialysis along with any changes in the last 24-48 hours. There was a space for assessment of the dialysis site and a place for wet and dry weights and concerns/comments/orders. On 2/21/19 at 12:25 PM an interview was conducted with the facility's Nurse Consultant after a request was made to review the dialysis communication sheets for Resident #118. The Nurse Consultant stated this resident did not have a communication book prepared and the nurses had been communicating with dialysis by phone. The only communication with dialysis documented in the progress notes was dated 2/13/19 at 3:18 PM when the facility called dialysis regarding the insertion of an access line. On 2/22/19 at 9:30 AM the Director of Nursing (DON) stated in an interview the communication book for Resident #118 was overlooked and had not been set up (there were no communication sheets). The DON further stated she expected the staff to look at the communication sheet in the communication book when the resident returned from dialysis for any communication from the dialysis unit.	F 698	frequency of monitoring.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		3/22/19

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F 761	Continued From page 26 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of manufacturer's specifications the facility failed to refrigerate medications as required and failed to date medications when opened for 2 of 2 medication refrigerators and 3 of 5 medication carts observed. The facility also failed to maintain a medication refrigerator at the specified temperature for medication storage for 1 of 2 medication refrigerators. The findings included: 1. Purified Protein Derivative (PPD) is a skin test	F 761	F 761 Label/Store Drugs and Biologicals (1) The 2 open vials of Purified Protein Derivative (PPD) Solution that were opened and not dated, was discarded and reordered per policy by the hall nurse on 2/21/19. The Levemir Insulin on the 400 hall medication cart was discarded and reordered per policy by the hall nurse on 2/21/19. The Xalatan Eye Drops on the 200 hall medication cart was discarded and reordered per policy by the hall nurse	

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F 761	Continued From page 27 used in the diagnosis of tuberculosis. The manufacturer's package insert for PPD says a vial of PPD that has been entered and in use for 30 days should be discarded. On 2/21/19 at 2:01 PM an observation of the medication refrigerator used to store medications for the 900, 1000, and 1100 Halls was made with Nurse #8. There were 2 opened bottles of PPD and approximately one quarter of the medication remained in the bottle. There was no date on the bottles to show when the bottles were opened. During the observation, Nurse #8 confirmed there was not a date on the bottles and stated the vials of PPD were good for 30 days after they were opened. On 2/22/19 at 9:24 AM the Director of Nursing (DON) stated in an interview she expected the nurses to date medications when opened. 2. Levemir Insulin is a long acting insulin used to treat diabetes mellitus. The manufacturer's package insert advised to store unopened vials in the refrigerator and to dispose of any vial that had been open for more than 42 days. On 2/21/19 at 2:16 PM an observation of the medication cart on the 400 Hall was made with Nurse #2 and revealed an unopened vial of Levemir insulin. The label on the container read: "Store in the refrigerator until opened." It was also noted on the vial "expires 6 weeks after opened." The vial of insulin was not dated with the date it was removed from the refrigerator. During the observation, Nurse #2 stated the resident had another vial of Levemir insulin on the medication cart and the unopened vial was delivered by the pharmacy last night. Xalatan eye drops are used to treat high pressure in the eye or glaucoma. The manufacturer's package insert for Xalatan eye drops advised to store unopened Xalatan eye	F 761	on 2/21/19. (2) All medications were removed from the 100/300 medication room refrigerator and discarded on 2/21/19 by the hall nurse. Replacement medications were ordered per policy on 2/22/19 by the hall nurse. The 100/300 medication room refrigerator temperature gauge was adjusted to the proper temperature setting by maintenance on 2/22/19. (1) 100% audit will be completed by 03/22/19 by the RN Supervisor of all medications inside the medication carts and medication rooms to include 100, 200, 300, 400 hall. This audit is to ensure all medications to include PPD, biologicals, and Xalatan, were dated when opened and stored per manufacture specifications. Any area of concern was addressed during the audit by the RN Supervisor by discarding and reordering medications per policy. (2) 100% audit will be completed by 3/22/19 by the RN Supervisor of all medication refrigerator temperature to ensure that temperatures are maintained at a range of 36-46 F. Any area of concern was addressed during the audit by the RN Supervisor by discarding and reordering medications per policy and adjusting the refrigerator temperature gauge. 100% in service was initiated on 2/21/19 by the Director of Nursing with all nurses to include nurse # 8, # 2, # 9 and medication aides regarding checking medication carts and medication rooms daily to ensure that PPD, biologicals, and	

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F 761	Continued From page 28 drops in the refrigerator until opened and once opened, store at room temperature for up to 6 weeks. There were also 2 unopened bottles of Xalatan eye drops on the medication cart that were not dated to show when the bottles were removed from the refrigerator. One bottle was dispensed by the pharmacy on 2/13/19 and the other bottle on 2/20/19. On 2/22/19 at 9:24 AM the Director of Nursing stated in an interview she expected the nurses to read the labels to see how the medication was to be stored and expected the medications to be dated when opened. 3. On 2/21/19 at 2:34 PM an observation of the medication refrigerator used to store medications for residents on the 100 and 300 Halls was made with Nurse #9. A temperature chart was posted on the door of the refrigerator that listed 3 different temperature ranges one of which was Med (Medication) Room Refrigerator and noted the temperature should be 36-46 degrees Fahrenheit. The daily temperatures recorded on the chart were recorded as follows: 2/20/19 AM Temp 34 degrees, PM temp 34 degrees. 2/21/19 AM Temp 34.7 degrees and PM Temp 34 degrees. 2/22/19 AM Temp 34 degrees. The bottom of the sheet listed Corrective Action and noted if the temperature was out of range to notify the maintenance department and the manager. It was also noted to retake the temperature in one hour. There were multiple insulin vials and Purified Protein Derivative (PPD) stored in the refrigerator. The manufacturer's package insert said to store insulin at 36 to 46 degrees Fahrenheit and the package insert for PPD said to store the medication at 35 to 46 degrees Fahrenheit.	F 761	Xalatan are dated and stored per manufacture specifications; ensuring medication room refrigerators maintain the appropriate temperature range of 36-46F; and the process to follow when refrigerated temperatures are out of range to include adjustment of the refrigerator temperature gauge and notification of maintenance. All newly hired nurses and medication aides will receive the in service during orientation by the Staff Facilitator. This in-service will be completed by 3/22/19. 100 % of all medication carts, medication rooms and medication room refrigerator temperatures to include medication carts on the 100, 200, 300, and 400 halls and the 100/300 medication room refrigerator will be monitored by the RN Supervisor using a Medication/Temperature QI Tool weekly x 8 weeks then monthly x 1 month. This audit is to ensure that all medications inside the medication carts and medications rooms to include PPD, biologicals, and Xalatan, were dated when opened and stored per manufacture specifications. This audit is also to ensure that medication room refrigerator temperatures are being checked, maintained between 36-46 degrees and adjusted when out of range with notification to maintenance. The nurse or medication aide will be immediately re-trained during the audit and medication discarded and reordered per policy by the RN Supervisor for any identified areas of concern. The Director of Nursing will review and initial the	

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F 761	Continued From page 29 On 2/22/19 at 11:10 AM the Director of Nursing stated the unit manager told her she was looking at the temps for the nourishment/patient refrigerators listed on the temperature chart posted on the front of the refrigerator that read 31 to 42 degrees Fahrenheit and not the medication refrigerator temperature listed as 36 to 46 degrees Fahrenheit. On 2/22/19 at 9:24 AM the Director of Nursing (DON) stated in an interview she expected the night supervisor or the night nurse to check the refrigerator temperature and to know what the parameters were supposed to be and contact maintenance if the medication refrigerator was not in the range required to store medications. 4. Purified Protein Derivative (PPD) is a skin test used in the diagnosis of tuberculosis. The manufacturer's package insert for PPD says a vial of PPD that has been entered and in use for 30 days should be discarded. On 2/21/19 at 2:34 PM an observation was made of the medication refrigerator used to store medications for residents on the 100 and 300 Halls with Nurse #9. There was one vial of PPD that had been opened and was approximately three quarters full. There was not a date on the vial to show when the bottle had been opened. Nurse #9 confirmed there was not a date on the vial and stated the medication was good for 30 days after it was opened. On 2/22/19 at 9:24 AM the Director of Nursing stated in an interview she expected the medications to be dated when opened. 5. Xalatan eye drops are used to treat high	F 761	Medication/Temperature QI Tool for completion and to ensure all areas of concerns were addressed weekly X 8 weeks then monthly X 1 month. The Director of Nursing will forward the results of the Medication/Temperature QI Tool to the Executive Quality Improvement Committee monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 761	Continued From page 30 pressure in the eye or glaucoma. The manufacturer's package insert advised to store unopened Xalatan eye drops in the refrigerator until opened and once opened, store at room temperature for up to 6 weeks. On 2/21/19 at 2:42 PM an observation was made of the medication cart used for residents on the 200 Hall. There was one unopened bottle of Xalatan eye drops on the cart that was dispensed by the pharmacy on 2/19/19. The label on the container read: "Refrigerate until opened." There was also a label on the container that read: "Expires 6 weeks after opening." On 2/22/19 at 9:24 AM the Director of Nursing stated in an interview she expected the nurses to read the labels to see how the medication was to be stored and expected the medications to be dated when opened.	F 761		
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 record review and staff interviews, the facility Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put in place in June 2018. This was for a deficiency that originally was cited on 6/1/2018 and was subsequently recited on the current recertification survey of 2/22/2019. The	F 867	F867 QAPI/QAA Improvement Activities The Administrator, Director of Nursing (DON) Quality Improvement (QI Nurse), and Registered Nurse Supervisors (RN Supervisor), will be educated by the corporate consultant on the QA process, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the	3/22/19

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F 867	Continued From page 31 repeated deficiency was in the area of dialysis documentation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F-698 Dialysis: Based on observation, record review and staff interview the facility failed to provide ongoing communication documentation with the hemodialysis center for 1 of 1 resident reviewed for dialysis and failed to document an assessment of the resident's status, shunt site and vital signs upon returning to the facility after dialysis (Resident #118). During the facility's prior June 2018 recertification survey, they failed to monitor a dialysis residents access/shunt site, failed to provide nursing assessments for a resident after dialysis treatments and failed to provide ongoing communication documentation with the hemodialysis center for 1 of 1 residents reviewed for dialysis (Resident #72). On 2/22/2019 at 10:21 AM, an interview was conducted with the Administrator. The Administrator stated the staff had been in-serviced for checking the dialysis access site and the Medication Administration Record, documenting the assessment, and completing the dialysis progress notes. The Administrator stated the he was unable to find the end results of the audits and was unaware the documentation was not being completed.	F 867	QA process, including identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. The Administrator will complete 100% audit of previous citation action plans within the past year to include dialysis. This audit is to ensure that the QA committee has maintained and monitored interventions that were put into place by 3/22/19. Action plans will be revised and updated and presented to the QA Committee by the Administrator by 3/22/19 for any identified concerns. All data collected for identified systemic concerns and current citations to include dialysis will be taken to the Quality Assurance committee by the Administrator for review monthly x 3 months. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is required, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Medical Records Manager. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the	

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F 867	Continued From page 32	F 867	need and/or frequency of continued monitoring.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the	F 883		3/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 02/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 883	Continued From page 33 benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document the provision of education regarding risks/benefits for 1 of 1 resident who refused the influenza vaccine (Resident #27) and for 1 of 4 residents who received the influenza vaccine (Resident #83). The findings included: The facility's policy titled Immunizations and revised on 10/18/17 read: "Before offering the influenza vaccine, resident or residents' legal representatives will be provided education regarding the benefits and potential side effects of these immunizations with documentation in the medical record." 1. Resident #27 was admitted to the facility on 5/25/17 and had a diagnosis of congestive heart	F 883	F 883: Influenza and Pneumococcal Immunizations Resident # 27 was reoffered the influenza vaccination with provision of education provided regarding risk/benefits on the influenza vaccination prior to making a decision with documentation in the clinical record by 3/22/19 by the Quality Improvement (QI) Nurse. Resident # 83 will be educated by the QI Nurse on the influenza vaccination with provision of education regarding risk/benefits on the influenza vaccination with documentation in the clinical record by 3/22/19. Provisional education regarding risk/benefits will continue to be provided prior to the decision to receive or decline the vaccination.	

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F 883	Continued From page 34 failure, diabetes mellitus, cerebrovascular accident (stroke) and chronic obstructive pulmonary failure (COPD) with respiratory failure. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 11/22/18 revealed Resident #27 was cognitively intact. An Immunization Update form dated 12/6/18 noted Resident #27 refused the influenza vaccine. The form noted a space to indicate the education was provided to the resident/family. There was no information on the form to show the resident was provided the risks and benefits of receiving/refusing the influenza vaccine. On 2/22/19 at 9:16 AM the Director of Nursing (DON) stated in an interview the social worker obtained the permission for the influenza vaccines and documented in the clinical record whether the resident consented or refused the vaccine. On 2/22/19 at 10:02 AM Social Worker #1 and Social Worker #2 were interviewed. Social Worker #1 stated they got verbal consents from alert and oriented residents for the influenza vaccine but did not provide the education at that time. On 2/22/19 at 11:09 AM a separate interview with the DON revealed the social workers did not provide the education for the influenza vaccine but when the nurse went in to give the injection she was supposed to provide the education piece prior to giving the vaccine. 2. Resident #83 was admitted to the facility on	F 883	100% audit of all resident medical records to include residents # 27 and # 83 were reviewed to determine if the influenza vaccination had been administered or declined with provisional education on risk/benefits provided with documentation in the clinical record on 3/15/19 by the Director of Nursing. Education will be provided to any resident or resident representative that has not received the education with documentation in the clinical record by 3/22/19. 100% in-service for all nurses was completed by 3/22/19 regarding providing education and documentation in the clinical record of provisional education regarding risk/benefits on the influenza vaccine to the resident and/or resident representative prior to the decision to receive or decline the vaccination. 10% of all residents to include resident # 27 and # 83 will be reviewed by the (QI) Nurse weekly for 8 weeks and monthly x 1 month utilizing the influenza vaccine audit tool. This audit is to ensure that all residents receive provisional education regarding risk/benefits of the influenza vaccine prior to the decision to receive or decline the vaccination. Any identified areas of concerns will be addressed during the audit by retraining the nurse by the Quality Improvement Nurse. The Director of Nursing will review and initial the influenza vaccine audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of	

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F 883	Continued From page 35 5/19/14 and had a diagnosis of arthritis, hypertension and a history of pneumonia. The Quarterly Minimum Data Set (MDS) Assessment dated 10/9/18 revealed Resident #83 was cognitively intact. An Immunization Update form dated 10/19/18 noted Resident #83 consented to receive the influenza vaccine. There was a space to indicate the provision of education provided to the resident/family. There was no information on the form to show the resident was provided the risks and benefits of receiving the influenza vaccine. On 2/22/19 at 9:16 AM the Director of Nursing (DON) stated in an interview the social worker obtained the permission for the influenza vaccines and documented in the clinical record whether the resident consented or refused the vaccine. On 2/22/19 at 10:02 AM Social Worker #1 and Social Worker #2 were interviewed. Social Worker #1 stated they got verbal consents from alert and oriented residents for the Influenza vaccine but did not provide the education at the time. On 2/22/19 at 11:09 AM a separate interview with the DON revealed the social workers did not provide the education for the influenza vaccine but when the nurse went in to give the injection she was supposed to provide the education piece prior to giving the vaccine.	F 883	concern were address. The Director of Nursing will forward the Influenza vaccine audit tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the Tools monthly x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	