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	345307	A. BUILDING _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to honor a resident's choice for medication administration times for 1 of 1 resident reviewed for choices (Resident #1). Findings included:	F 561	1.The facility failed to ensure that resident #1 medication administrations time choice was changed from 9pm to 7pm; however, as of 5/25/19 resident #1 medication administrations time was changed to 7pm. In order to ensure	6/20/19

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

Electronically Signed | 06/20/2019

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F 561	Continued From page 1 Resident #1 was admitted to the facility 03/14/19 with diagnoses including hypertension (high blood pressure) and peripheral vascular disease. Review of the admission Minimum Data Set (MDS) dated 03/27/19 revealed Resident #10 was cognitively intact. Review of Resident #1's medical record revealed a Physician's order dated 04/05/19 stating night time medication administration time was to be changed to 7:00 PM. An interview with Resident #1 on 05/22/19 at 11:44 AM revealed he liked to take his night time medications at 7:00 PM. Resident #1 stated he had asked to get his night time medications at 7:00 PM but did not usually get his medications until 9:00 PM or 10:00 PM. An interview with Nurse #4 on 05/22/19 at 1:01 PM revealed Resident #1 was upset because his night time medications were scheduled to be administered at 9:00 PM. She stated Resident #1 requested to receive his night time medications at 7:00 PM and she obtained a Physician's order to change the night time medication administration time from 9:00 PM to 7:00 PM. Review of Resident #1's Medication Administration Record (MAR) for May 2019 revealed his night time medications were scheduled to be administered at 9:00 PM. A subsequent interview with Nurse #4 on 05/22/19 at 6:35 PM revealed she was not sure why Resident #1's night time medication administration time was changed to 9:00 PM. Nurse #4 stated when she obtained the	F 561	2.All residents have the potential to be affected by the deficient practice.In order to ensure that no other residents were affected by the deficient practice regarding the medication time change, the Director of Nursing and Administrator have completed and audited the physician order changes of residents medication administration Records times from 5/27/209-5/31/2019 no other adverse effects were found. 3.The measures that were put in place in order to ensure that the deficient practice will not recur, all license nurses and Med aides were educated on 6/5/2019 regarding ensuring accuracy of medication administration times when reconciling physician orders; in addition, the above education will be included in subsequent new hire orientation. 4. Monitoring to ensure compliance and solutions are sustained starting on 6/10/19 the Director of Nursing and or license nurses will randomly audit five (5) residents one (1) x per week medication administration times on the Mars' against the physician orders for 4 weeks then three (3) residents one (1) x per week x's four (4) weeks. 5. All plan of correction audit data will be reported by the Director of Nursing and or Administrator to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in	

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F 561	Continued From page 2 Physician's order to change the night time medication administration time for Resident #1 she faxed the Physician's order to pharmacy and changed the medication administration times on the April 2019 MAR. She stated the pharmacy should have changed the night time medication administration time to 7:00 PM on the May 2019 MAR. Nurse #4 reviewed Resident #1's medical record and confirmed the last Physician's order for medication administration time was the order she obtained on 04/05/19. An interview with the Director of Nursing (DON) on 05/22/19 at 6:50 PM revealed the last Physician's order regarding medication administration time was dated 04/05/19 and stated to change Resident #1's night time medication administration time to 7:00 PM. She stated the pharmacy should have changed the medication administration times to 7:00 PM for May 2019 MARs. She stated when MARs were changed from month to month nurses were responsible for checking the new month's MAR for accuracy. The DON stated the nurses checking the May 2019 MAR should have ensured the night time medication administration times were correct. An interview with the Physician on 05/23/19 at 2:42 PM revealed he did not have a preference on whether Resident #1's night time medications were given at 7:00 PM or 9:00 PM but since Resident #1 requested his night time medications be given at 7:00 PM they should have been given at 7:00 PM. An interview with the Administrator on 05/23/19 at 10:19 PM revealed she expected residents' MAR to contain the correct medication administration	F 561	compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 6/20/19	

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F 561	Continued From page 3 times per Physician orders and the resident's choice.	F 561		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family and staff interviews, the facility failed to provide 1 of 1 resident (Resident #12) or their representative with quarterly statements of their personal trust fund account managed by the facility and the facility failed to maintain accurate personal trust fund account records for 1 of 23 residents (Resident #14). Findings included: 1. Resident #12 was admitted to the facility on 7/24/15. A review of the quarterly Minimum Data Set (MD) dated 3/07/19 coded Resident #12 with moderately impaired cognition and could understand and be understood.	F 568	F568 requires the facility to ensure residents or their representatives receive at least quarterly statements of the residents trust accounts. 2. No residents were harmed as a result of the deficient practice. All residents with a facility resident trust account or their representative have received a current trust statement as of 6/18/2019 for the months of January 2019-March 2019. Resident #14 $500 was credited back on the account on 5/24/2019 by the Corporate Accounts Receivable (AR) Consultant. 3. All residents with a facility resident trust account have the potential to be affected	6/20/19

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F 568	Continued From page 4 An interview on 5/22/19 at 11:36 AM with Resident #12 revealed she had a personal trust fund account that was managed by the facility. She reported she had not received any statements from the facility letting her know how much money she had in her account. An interview on 5/23/19 at 6:59 PM with Resident #12's Responsible Party (RP) revealed they had not received any statements from the facility for Resident' #12's personal trust fund account. The RP also revealed she had discussed this with the Business Officer Manager (BOM) and ensured he had the correct mailing address for the quarterly statement. An interview on 5/23/19 at 1:57 PM with the Corporate Accounting Officer revealed the prior Corporate Accounting Officer was supposed to print quarterly statements for the resident or their RP and she was not aware they had not been done. She also revealed the Business Office Manager would be taking over this function at the end of the current quarter. The Corporate Accounting Officer stated the RP was supposed to get the quarterly statement, but a copy would also be given to alert and oriented residents. 2. Resident #14 was admitted to the facility on 5/14/15. An interview with the Business Office Manager (BOM) on 5/23/19 at 9:15 AM revealed there was $500.00 debit for Resident #14's personal funds account on 5/22/19 titled Spend Down. The Business Office Manager stated he would notify the resident's family when the resident's personal funds account got close to the amount which	F 568	by the deficient practice,thus the following corrective actions have been taken; as a means to ensure ongoing compliance the Business Office Manager have received in-serviced on 5/27/2019 on the facility's Policy and Procedure regarding Resident's Trust and quarterly statements by the Administrator. The Administrator had also spoken with the AR Consultant on 5/24/2019 with the Business Office Manager (BOM) present that no money is to be debited from any resident's account unless the check has been signed by the Administrator and mailed out to the responsible party or resident. As of 5/27/19 the BOM is responsible for debiting the resident trust account so that the deficient practice will not recur. 4. Monitoring to ensure solutions are sustained the Account Receivable Consultant and or Administrator will audit residents' quarterly statements signing off statements have been printed and mailed every quarter for one year starting the second quarter of 2019 resident's statements which will go out July 6th 2019 for the Months of April 2019-June 2019.In addition, resident trust accounts ledger and receipts will be audited and signed off on by the Administrator and or designee for one (1)x per week x's one year starting 6/28/2019 in order to verify accuracy and ensure that solutions are sustained. 5. The plan of correction will be submitted	

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F 568	Continued From page 5 would affect the resident's qualification for Medicaid. He further stated he had not written the check for this yet so this entry was an error and the $500.00 would be credited to Resident #14's account and would not be debited to Resident #14's account until the check had been written and signed. The Business Office Manager stated he usually waited until the check had been written and signed before entering the debit to the resident's personal funds account but had not done that this time. An interview on 5/23/19 at 1:57 PM with the Corporate Accounting Officer revealed a debit should not have been entered in Resident #14's personal funds account until the check had been written and signed. She further revealed that credit would be entered to Resident #14's personal funds account for $500.00 to return the funds to the resident until the check had been written and signed. An interview on 5/23/19 at 11:05PM with the Administrator revealed it was her expectation that each resident who had a personal trust fund account receive a quarterly statement as required. She also revealed it was her expectation that each debit on a personal trust fund account would be entered accurately and only with a receipt. The Administrator also stated a debit should not be entered on a resident's personal funds account until the check had been written and signed.	F 568	by the Accounts Receivable Consultant and or Administrator to the Quality Assurance Committees and the results of the audits will be reviewed quarterly and become a topic of the Monthly Quality Assurance Committee meeting to ensure that compliance is sustained and concerns are identified and address with the plan of action adjusted accordingly as warranted. The above corrective action will be completed by 6/20/19.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		6/20/19

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F 583	Continued From page 6 confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to protect private health information by leaving confidential medical information in an area accessible to the public for 1 of 1 resident observed for fingerstick blood sugar checks (Resident #4).	F 583	The facility failed to ensure that resident #4 confidential medical information was in a secured and protected area that was not accessible to the public. 2.All residents confidential medical	

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F 583	Continued From page 7 Findings included: Resident #4 was admitted to the facility on 10/02/17 with diagnoses including diabetes and heart failure. An observation on 05/22/19 at 11:33 AM of Nurse #3 revealed she opened the Medication Administration Record (MAR) on the 100 A hall medication cart at the nurse's desk. Nurse #3 left the MAR open with Resident #4's confidential medical information exposed and walked 48 feet down the 100 hall to Resident #4's room and checked his fingerstick blood glucose. At 11:58 AM Nurse #3 left Resident #4's room and returned to the nurse's desk where the MAR remained open and Resident #4's confidential medical information remained exposed. Nurse #3 recorded Resident #4's fingerstick blood glucose result and closed the MAR. An interview with Nurse #3 on 05/22/19 at 1:17 PM revealed she should not have left the MAR open and unattended while she went to check Resident #4's fingerstick blood glucose. She stated she should have closed the MAR or put a piece of paper over Resident #4's confidential medical information. Nurse #3 stated she covered resident's confidential medical information and was not sure why she did not earlier on 05/22/19. An interview with the Director of Nursing (DON) on 05/23/19 at 5:21 PM revealed she expected residents' confidential medical information to be covered when unattended either by placing a paper over the information or by closing the MAR.	F 583	information has the potential to be affected by the deficient practice. To ensure that no other resident was affected by the deficient practice the Medical Director conducted an Med pass audit with the 7am to 7pm licensed Nurses on 5/24/2019 to ensure that Mars were covered during the Med-pass and no adverse effects were found. 3. All staff were in-serviced on 5/30/2019 regarding HIPPA which included Resident's personal privacy/confidentiality of records to assist in ensuring that the deficient practice will not recur. The above education will be included in subsequent new-hire orientations. 4. In order to ensure that solutions are sustained the DON and or Designee will monitor the medication pass one (1) x a week x's four (4) weeks then one (1) x a week x's four (4) weeks to ensure that confidentiality of resident's medical records are secured and protected starting on 6/7/2019. Data will be summarized and presented to the facility quality Assurance Performance improvement Committee meeting by the DON and or Administrator and reviewed for two (2) Months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator	

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F 583	Continued From page 8 An interview with the Administrator on 05/23/19 at 10:19 PM revealed she expected residents' confidential medical information to be covered when unattended.	F 583	are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 6/20/19	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide incontinence care for 2 of 4 dependent residents (Resident #'s 6 and 9) reviewed for assistance with activities of daily living. Findings included: 1. Resident #6 was admitted to the facility on 05/14/18 with diagnoses which included chronic obstructive pulmonary disease (COPD), congestive heart failure and dementia. Review of Resident #6's most recent quarterly Minimum Data Set (MDS) dated 02/20/19 revealed she was severely cognitively impaired for daily decision making and required extensive assistance with most activities of daily (ADL) including incontinence care. The resident was incontinent of bowel and bladder and wore briefs. Review of Resident #6's care plan dated 02/27/19 revealed she was care planned for ADL/self-care	F 677	1. Incontinence care was provided to resident #6 by CNA # 1 and CNA #2 on 5/22/19 and incontinence care was provided to resident #9 on 5/23/19 by CNA #3 and Nurse #2. 2. All residents have the potential to be affected by the deficient practice; however, in order to ensure the facility is able to identify others residents that have the potential to be affected the DON had conducted a audit on 5/24/19 on 25 random residents to ensure that incontinence care was provided and no adverse effects were found. 3.The Nursing staff were provided in-service on 6/3/19, 6/4/19,and 6/19/19 by the Administrator regarding providing effective incontinence care. In addition, in order to ensure the deficient practice does not recur and residents do not go hours without being changed as of 5/27/2019	6/20/19

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F 677	Continued From page 9 performance deficit related to dementia, advanced COPD, limited mobility and advanced age. The goal was for the resident to have care needs met as evidenced by her neat appearance with her assistance as able through the review date. The interventions included the resident required extensive assistance of staff for toileting needs. Toilet routinely and as needed. An interview was conducted on 05/22/19 at 10:00 AM with one of Resident #6's family members. The family member was interviewed in the resident's room with the resident present and a urine odor was noted in the room. The family member stated during the morning of 5/22/19 he had been with Resident #6 in the resident's room since before 7:00 AM. The family member explained Resident #6 had remained in bed and staff had not checked the resident during the morning of 5/22/19 to see if she needed incontinent care or if her incontinent brief needed to be changed. An interview on 05/22/19 at 10:15 AM with Nursing Assistant (NA) #1 revealed she was responsible for taking care of Resident #6 during the 7:00 AM to 3:00 PM shift on 05/22/19. NA #1 was informed by the surveyor that Resident #6's family member stated the resident needed incontinence care. NA #1 stated her shift began at 7:00 AM, but she had not provided Resident #6 with any care during her shift. NA #1 stated she would have to find someone to help with her care for Resident #6 and would change the resident when another NA was available to assist. NA #1 stated the resident was total care now and required 2 staff to change her brief. An observation on 05/22/19 at 12:45 PM of NA #1	F 677	CNA's have been asking cognitive residents if they need to go to the rest room. As of 5/27/19 all residents non-cognitive as well as cognitive toileting is done during morning ADL care, before or after lunch, before or after dinner and as needed. In addition incontinence care being received in a timely manner will be included in the nursing assistance monthly mandatory in-service. 4. Monitoring to ensure that solutions are sustained the Director of Nursing and or Administrator will randomly check the skills of two different Certified Nursing providing incontinence care on 10 random residents 3x's per week x's 4 weeks then 2 x's per week x's 4 weeks starting 6/17/19 to ensure that they are checking resident's for the smell of urine and or wet clothing to ensure compliance is maintained. Data will be summarized and presented to the facility quality Assurance Performance improvement Committee meeting Monthly x's two months by the Director of Nursing and or Administrator . Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction.	

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F 677	Continued From page 10 and NA #2 providing incontinence care revealed Resident #6's brief was saturated from front to back with urine, balling with some of the inside of the incontinent brief sticking to the resident's back and a strong odor of urine was noted when the brief was opened. An interview on 05/22/19 at 3:00 PM with NA #1 revealed during the 7:00 AM to 3:00 PM shift on 5/22/19 she did not provide any care to Resident #6 prior to 12:45 PM and stated she had not checked the resident's brief or changed her brief until 12:45 PM. NA #1 stated during the morning of 05/22/19 she was assisting the Administrator to find staffing sheets. NA #1 stated at the time she was the only one assigned to care for the residents on the 100 hall. NA #1 stated, she was also assigned other duties including: the lead NA, transporter at times, restorative NA and was responsible for staffing. NA #1 also stated she usually did not have a full resident care assignment due to her other duties, but today she was given a full assignment due to there not being enough staff. NA #1 stated the residents were supposed to be checked every 2 hours and changed if wet. She stated she had not checked or changed Resident #6 for incontinence every 2 hours during the morning of 05/22/19. An interview on 05/23/19 at 3:00 PM with Resident #6's responsible party (RP) revealed she and another family member had been constantly with the resident since the morning of 05/23/19. The RP stated staff had not changed the resident's incontinent brief since around 9:30 AM on 5/23/19 when the Hospice NA changed the resident. The RP stated she knew the resident had not been changed since around 9:30 AM because she and another family member had not	F 677	Corrective action will be completed by 6/20/19	

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left the resident's bedside since the morning.

An interview on 05/23/19 at 3:30 PM with NA #2 revealed she was responsible for Resident #6's care when she came in to work on 5/23/19 at 10:00 AM. NA #2 stated she typically worked second shift but had come in early to help staff care for the residents. She stated she would change the resident when another NA was available to assist her. NA #2 stated Resident #6 was total care now and required 2 people for changing her brief. NA #2 confirmed she had not provided incontinent care on the resident since the Hospice NA had changed the resident around 10:00 AM.

An observation on 05/23/19 at 5:30 PM of NA #2 and NA #3 providing incontinence care revealed Resident #6's brief was saturated from front to back, balling in the center and there was a strong odor of urine when the brief was opened.

An interview on 05/23/19 at 7:00 PM with NA #2 revealed she had taken care of the resident since she came in at 10:00 AM and had checked the resident around 11:30 AM and she was not wet. NA #2 stated Resident #6 was total care now and required 2 people for changing her brief and stated she had to wait until someone was available to assist her.

An interview on 05/23/19 at 10:00 PM with the Director of Nursing (DON) revealed it was her expectation that residents be checked and changed as needed every 2 hours and more often if required. The DON also stated their staffing levels were not where she wanted them to be and hoped with hiring staff would enable her to increase the number of Nursing Assistants

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(NAs) working on the halls. The DON stated it was her plan to have 2 NA's on each hall to care for the residents. The DON also stated it was her expectation that the NAs ask for help from the nurses and other staff when needed.

An interview on 05/23/19 at 10:15 PM with the Administrator revealed she did not believe that her residents went for hours without being checked and changed. She stated her expectation was for residents to be changed, dry and given excellent quality of care in a timely manner. The Administrator stated she did not expect residents to wait hours to be changed. The Administrator stated the NAs should ask for help when needed to provide incontinence care to total care residents like Resident #6.

2. Resident #9 was admitted to the facility on 08/16/18 and readmitted on 10/10/18 with diagnoses which included non-Alzheimer's dementia without behaviors.

Review of Resident #9's most recent quarterly Minimum Data Set (MDS) dated 04/11/19 revealed he was severely cognitively impaired for daily decision making and required total assistance with most activities of daily living (ADL) including toileting. The resident was incontinent of bowel and bladder and wore briefs.

Review of Resident #9's care plan dated 04/15/19 revealed he was care planned for ADL/self-care performance deficit related to dementia, limited mobility and visual impairment and was at risk of developing complications associated with decreased ADL self-care performance. The goal was for the resident to remain clean, appropriately groomed and appropriately dressed,

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with staff assistance as needed through review date. The interventions included to anticipate the resident's needs and provide prompt assistance. Provide total assistance with incontinence care as needed.

An interview on 05/23/19 at 5:55 PM with Resident #9's family revealed she had just returned to the facility to assist the resident with his dinner and found him in bed with his pants pulled down to his upper thighs and the pants were wet. The family member put on his call light and NA #2 came in and turned the light off and stated she would be back to change him and left him without covering him up. The family member stated it looked to her as though they had gone in to the room to change the resident, started and left before finishing. She stated the facility was grossly understaffed and residents were not being changed as they should be. The Director of Nursing (DON) walked up during the conversation and observed the resident and stated she would get someone to come clean him up and change him.

An observation on 05/23/19 at 6:25 PM of NA #3 and Nurse #2 providing incontinence care revealed Resident #9's brief was saturated from front to back with urine, balling in the middle and there was a strong odor of urine when the brief was opened. The resident's pants had two distinct circles of urine on the back of the pants and were wet. The resident had dried bowel movement on his buttock area as well as a soft bowel movement on his bottom. A new brief was applied and secured, and clean pants placed on the resident. A new pad was applied to the bed and the resident was assisted up in the chair for his dinner.

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An interview on 05/23/19 at 6:50 PM with NA #3 and Nurse #2 revealed it did not appear to them the resident had been changed for some time given the amount of urine in his brief and given the fact that his pants were wet as well.

An interview on 05/23/19 at 7:00 PM with NA #2 revealed she had taken care of the resident since she came in at 10:00 AM and had checked him earlier and he was not wet. NA #2 stated the resident must have pulled his pants down himself because she had not done that. NA #2 stated she had answered the light when the family member put it on and told her as soon as she finished passing trays she would be back to change him but stated someone else changed him before she could get back to him.

An interview on 05/23/19 at 10:00 PM with the Director of Nursing (DON) revealed it was her expectation that residents be checked and changed as needed every 2 hours and more often if required. The DON also stated their staffing levels were not where she wanted them to be and hoped with hiring staff would enable her to increase the number of Nursing Assistants (NAs) working on the halls. The DON stated it was her plan to have 2 NA's on each hall to care for the residents. The DON also stated it was her expectation that the NAs ask for help from the nurses and other staff when needed.

An interview on 05/23/19 at 10:15 PM with the Administrator revealed she did not believe that her residents went for hours without being checked and changed. She stated her expectation was for residents to be changed, dry and given excellent quality of care in a timely

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F 677	Continued From page 15 manner. The Administrator stated she did not expect residents to wait hours to be changed. The Administrator stated the NAs should ask for help when needed to provide incontinence care to total care residents like Resident #9.	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident,	F 725	No resident was affected by the deficient	6/20/19

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F 725	Continued From page 16 family and staff interviews, the facility failed to provide sufficient nursing staff resulting in incontinence care not being provided. This affected 2 out of 4 sampled residents (Resident #'s 6, and 9) reviewed for activities of daily living (ADL). Findings included: This tag is cross-referred to: 1.a. F677: Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide incontinence care for 2 of 4 dependent residents (Resident #'s 6 and 9) reviewed for activities of daily living (ADL). An interview on 05/22/19 at 2:55 PM with Nursing Assistant (NA) #1 revealed she was responsible for daily/weekly/monthly weights of all the residents, patient care, some transports, staffing and staffing sheets, and was the lead NA. She stated it was hard to get everything done with so many responsibilities and she did the best she could. NA #1 admitted she had not changed residents every 2 hours as indicated by their policy. An interview on 05/23/19 at 7:32 AM with Nurse #6 revealed they do not always have 3 NAs on night shift as needed. She stated they often work with 2 and have worked with just one. Nurse #6 stated she monitored the aides working with her and stated they were usually able to get their showers done but they were not always able to get residents up for breakfast or do rounds every 2 hours. The nurse stated they usually were able to get 2 rounds of incontinence care in at night.	F 725	practice. All residents have the potential to be affected by the deficient practice. In order to identify residents any resident that may have been affected by the deficient practice the Administrator conducted a interview with five residents on 5/24/19 concerning their care and staffing no complaints were made. Corrective action has been taken to help to enhance staffing and to ensure the deficient practice does not recur as of 6/3/19 the Administrator has obtained (hired) Nurses and certified nursing assistants for all three shifts from Dedicated Nursing Agency until the facility has completed their interview, orientation, and training process. In addition, in order to ensure the deficient practice does not recur and residents do not go hours without being changed as of 5/27/2019 CNA's have been asking cognitive residents if they need to go to the rest room. As of 5/27/19 all residents non-cognitive as well as cognitive toileting is done during morning ADL care, before or after lunch, before or after dinner and as needed. Education was provided to the staff regarding call offs and how it affects the facility, the residents', and their peers by the Administrator on 6/19/19. In addition,the Nursing staff were provided in-service on 6/3/19, 6/4/19,and 6/19/19	

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F 725	Continued From page 17 An interview on 05/23/19 at 8:15 AM with NA #4 revealed she worked night shift exclusively and stated she had worked with 1 other NA numerous times and it was difficult to get everything done. She stated they are usually able to get 2 rounds done and sometimes 3 but they did not have the staff to do rounds every 2 hours. NA #4 stated there had been times when she was the only NA at night and on those nights, she would only be able to do 1 round on the residents and was not able to do showers or get residents up in the morning. An interview on 05/23/19 at 10:47 AM with NA #6 revealed she worked day shift and stated they often worked short. She stated they were short staffed, people called out and stated there was no back up plan for call outs. She stated the Administrative staff do pull NAs in other positions and call people in to work if possible. NA #6 stated they usually do not change residents when they are passing trays unless it is an emergency and let the resident know they will be back to change them as soon as they are finished with passing everyone's tray. NA #6 stated day shift was difficult because there were 2 meals to deal with and that made it difficult to get rounds completed on the residents every 2 hours. NA #6 also stated it was difficult when there were residents that required 2 assists with everything. An interview on 05/23/19 at 11:27 AM with NA #2 revealed she typically worked 2nd shift but had been called in early to assist with resident care. NA #2 stated she had been called in early a lot lately due to call ins and short staffing. NA #2 stated it was difficult on day shift to get everything done unless there were 4 NAs working because a lot of the residents required 2 assists. NA #2	F 725	by the Administrator regarding providing effective incontinence care. Monitoring to ensure that solutions are sustained the Social worker and or designee will interview two (2)random competent residents from different shifts 5 x's per week x's one month than 2x's per week x's one month to determine staffing satisfaction and residents' needs are meet through staffing starting 6/19/2019. The Administrator will complete the schedules for the month of July and the DON will take over schedules once complete. The DON and or designee will be responsible for replacing call-outs and or no-shows starting 7/1/2019. Data will be summarized and presented to the facility quality Assurance Performance improvement Committee meeting Monthly x's two months by the Director of Nursing and or Administrator . Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 6/20/19	

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stated she did her best for the residents but stated she was limited at times because of the work load for 1st shift with having 2 meals and showers and residents to feed 2 meals. NA #2 stated it would be helpful in getting care done if there was more help on day shift.

An interview on 05/23/19 at 7:19 PM with the Director of Nursing (DON) revealed she was not currently working with the schedule but stated that would be changing in June. The DON stated they had hired some Nurses and some Nursing Assistants (NAs) but stated they were still in orientation and not ready to be placed on the schedule to work. The DON stated they had a hiring campaign and were hiring but it took time when half of the staff had left. She stated they had lost a lot of good staff and replacing them was going to take time. The DON further stated she had not had the control over staffing that she needed but that was scheduled to change in June.

An interview on 05/23/19 at 10:15 PM with the Administrator revealed she had hired some new Nurses and Nursing Assistants (NAs) and was in the process of trying to hire more. She stated she had a lot of staff leave and follow the previous DON and stated it took time to hire the right staff, so they would stay. The Administrator stated she had been fighting this challenge since coming to the facility. The Administrator explained the number of Staff scheduled per day was based on the census and the acuity of the residents in the facility. She added at the current census, her goal was to have 3 Nurses and 4 NAs scheduled to work on both the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and 2 Nurses and 3 NAs to work the 11:00 PM to 7:00

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F 725	Continued From page 19 AM shift. The Administrator said since starting her employment on 11/26/18 one of the issues she dealt with was staff not giving adequate notice when they called out of work which made it difficult to find a replacement to work their assignment which contributed to the facility being short-staffed. She explained as they have put processes, rules and regulations in place some of the staff have left due to not wanting to abide by the rules. The Administrator stated they currently had an Assistant Director of Nursing position, 2 Nurse positions on 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM, an evening Medication Aide position on 3:00 PM to 11:00 PM and 2 NA positions on 3:00 PM to 11:00 PM. She stated they were in the process of recruiting these positions and in the process of getting the staff that had been hired oriented and ready to work. The Administrator stated her goal was to continue to build her staff and get more staff in the building.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		6/20/19

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F 761	Continued From page 20 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard an opened expired bottle of Vitamin B1 tablets and an unopened expired bottle of B Liquid Complex gel capsules which were available for use in 1 of 2 medication carts, and an unopened expired bottle of Vitamin B1 tablets in 1 of 1 medication room. Findings included: An observation made of the facility's medication room with Nurse #3 on 5/22/19 at 10:08 AM revealed an unopened bottle of Vitamin B1 was stored in the cabinet labeled over-the-counter medications available for use. The label on this Vitamin B1 bottle indicated an expiration date of 3/2019. Interview conducted with Nurse #3 on 5/22/19 at 10:10 AM revealed she has been working at the facility for 2 weeks, and she was not sure who was responsible for checking the medication room for expired medications. Nurse #3 stated the Central Supply Clerk was responsible for stocking the medication room.	F 761	The facility failed to discard an opened expired bottle of Vitamin B1 tablets in medication cart and an unopened expired bottle of B liquid Complex gel capsules in medication room. 2.No resident was found to be affected by the deficient practice; however, there is the potential for all residents to be affected by deficient. In order to ensure that no resident was affected a Review of the facility medication carts and medication room was conducted by the Administrator on 5/24/2019 to ensure medications were not beyond the expiration date and no adverse effects were found. 3. Licensed nurses including Nurse #3 and Nurse #4 were re-educated by the Director of Nursing on 5/24/19 on checking expiration dates and discarding prior to expiration of medication. Central Supply Clerk was re-educated on 5/24/2019 on checking expiration dates	

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F 761	Continued From page 21 An observation made of the Medication Cart for the 300 hall with Nurse #4 on 5/22/19 at 11:30 AM revealed a bottle of Vitamin B1 tablets opened on 10/26/18 and available for resident use had an expiration date of 3/2019 and an unopened bottle of Vitamin B Liquid Complex gel capsules available for use had an expiration date of 3/2019. Interview conducted with Nurse #4 on 5/22/19 at 11:40 AM revealed the nurses were responsible for checking the medication carts for out of date/expired medications daily. Nurse #4 further stated she had just checked the Medication Cart for the 300 hall, but she did not notice the 2 medication bottles being outdated. Nurse #4 removed the 2 outdated medication bottles from the Medication Cart for the 300 hall. Nurse #4 further stated that she did not give any Vitamin B1 tablets that day. Interview with the Central Supply Clerk on 5/22/19 at 3:40 PM revealed he was responsible for ordering the over-the-counter (OTC) medications, but he maintained the supply in the downstairs central supply room. The Central Supply Clerk further stated he did not stock the medication room, and that the nurses were supposed to get the OTC medications from the downstairs central supply room when the supplies run low in the medication room. He checked the expiration dates of the OTC medications prior to stocking them in the downstairs central supply room. On 5/23/19 at 7:59 PM, the Director of Nursing (DON) was interviewed and stated it was the facility's policy that all the nurses were responsible for checking and maintaining the	F 761	and discarding prior to expiration of medication. 4. The Director of Nursing and licensed Nurses will Monitor Medication Carts and Medication room via direct observation 4 x's per week x 4 weeks then 2 x per week x's 4 weeks to ensure medications are not expired. The Central Supply Clerk will Monitor the Med room over the counter Meds 2x's per week x 4 weeks then 1 x per week x's 4 weeks stating 6/17/19 to ensure that solutions are sustained. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting Monthly x's two Months by the Administrator and or Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure compliance. The Director of Nursing and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on 6/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 22 medication room and the medication carts for out of date/expired medications. The DON further stated all expired medications should either be returned to the pharmacy or discarded. The DON stated that she did medication storage audits once a week, but she was unsure why the expired medications were left in the medication room and one of the medication carts. An interview conducted with the Administrator on 5/23/19 at 10:15 PM revealed that it was her expectation that all the nurses check the medication room and the medication carts daily for out of date/expired medications. She further stated she had instructed the Central Supply Clerk to check the OTC medications for expiration dates prior to stocking them in the Central Supply Room.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0468	A. BUILDING: _____ B. WING _____	05/24/2019

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L 006	.2104(C) REQUIREMENTS FOR LICENSE RENEWAL/CHANGE 10A-13D.2104 (c) The facility shall notify the Licensure and Certification Section of the Division of Facility Services within one working day following the occurrence of: (1) change in administration; (2) change in the director of nursing; (3) change in facility mailing address or telephone number; (4) changes in magnitude or scope of services; or (5) emergencies or situations requiring relocation of patients to a temporary location away from the facility. This Rule is not met as evidenced by: Based on record review and staff interviews the facility failed to notify Licensure and Certification Section of the Division of Health Service Regulation that the facility had experienced a change in Director of Nursing. The findings included: Upon entrance to the facility on 05/22/19 at 9:30 AM the Administrator indicated the Director of Nursing (DON) on file had left 11/27/18. The Administrator confirmed the name of the new DON and stated she had been at the facility since 04/11/19. An interview was conducted with the DON on 05/23/19 at 10:00 PM. The DON confirmed she had been the DON since 04/11/19. The DON stated she was not aware that the appropriate agency had not been notified and stated she thought the Administrator had taken care of the	L 006	The facility failed to notify the licensure and certification of the division of facility services within one working day that a new Director of Nursing was hired and the old Director of nursing had quit. No resident was affected by the deficient practice. The Administrator had received the proper form on 5/23/19 from the state and sent in the Director of Nursing Change of information to Licensure and Certification Section on 5/23/19. The Administrator and DON was re-educated regarding the Change form and who will send the Change in to the Licensure and Certification section by the Regional DON on 5/27/19.	6/20/19

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

Electronically Signed | 06/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0468	A. BUILDING: _____ B. WING _____	05/24/2019

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L 006	Continued From page 1 notification. An interview was conducted with the Administrator on 05/23/19 at 10:15 PM. The Administrator was asked for fax confirmation that she had notified the Division of the change in her DON. The Administrator stated she did not have proof because she had not sent in any paperwork and stated she was unaware she had to notify the Division when the DON at the facility changed. She stated she had had 5 different DONs since becoming the Administrator at the facility 11/27/18 and had not notified the Division of any of the changes.	L 006	Monitoring to ensure compliance the Administrator and DON will be responsible for sending any changes to the Licensure and Certification Section as of 5/23/2019 in order to ensure solutions are sustained. All plan of correction audit data will be submitted to the Quality Assurance Performance Committee at the next scheduled meeting and any issue and or trends identified will be addressed and changes will be made in order to ensure compliance. The Administrator and DON will be responsible for implementing and maintaining this plan of correction. Corrective action completed as of 6/20/19	