STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER SOUTHPOINT	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 06/18/19 through 06/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XMIW11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 6/21/19. Event ID# XMIW11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		7/19/19

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

Electronically Signed | 07/12/2019

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews, the facility failed to prevent the exposure of a resident's brief to others in the hallway for 1 of 1 cognitively impaired resident (Resident #59) reviewed for dignity. The Findings included: Resident # 59 was readmitted to the facility on 4/23/19 with diagnoses that included hemiplegia affecting the left side, major depressive disorder, vascular dementia, psychotic disorder and anxiety disorder. Resident # 59's most recent quarterly Minimum Data Set (MDS) dated 5/17/19, revealed Resident # 59 had no speech and rarely could make self-understood. The resident was assessed as cognitively impaired and needed extensive to total assistance of 1-2 people for activities of daily living (ADL). Resident was always incontinent of bowel and bladder.	F 550	Resident #59 is currently discharged to the hospital. Cognitively impaired residents that reside in the facility have the potential to be affected by the alleged deficient practice. DON/ADON/Unit Coordinators provided in services to facility staff beginning 6/22/19 - 7/15/19. Facility Staff included: Administration, Nursing, Therapy, Housekeeping and Dietary employees. Education will be included in new employee orientation. In service included: resident dignity, providing resident privacy, exposure, pulling privacy curtain, closing the door, ensuring resident is covered. DON/ADON/Unit Coordinators will randomly audit residents privacy, exposure and maintaining dignity. Audits	

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F 550	Continued From page 2 The review of Resident #59 's care plan dated 5/17/19 revealed the resident had a care plan for ADL related to hemiplegia, limited mobility, cognitive loss and communication. The goals included: the staff will anticipate resident's daily needs, the resident's needs will be met by being neatly dressed, groomed, clean and odor free. Interventions included allowing sufficient time for dressing and undressing. Resident# 59 required staff assistance related to dressing. Staff to observe, anticipate and meet resident's needs as resident may not be able to use call light due to dementia. During an observation on 6/18/19 at 2:37 PM, the door to Resident # 59's room was open. Resident # 59 was observed from the room's doorway lying in bed, wearing hospital gown that was raised above the abdomen, the lower half of the resident's body was covered by a bed spread below resident's knee. The resident's brief was visible from the hallway. Observations revealed the privacy curtain was not drawn around the resident's bed. During an interview with Nurse # 3 on 6/18/19 at 3:30 PM, nurse indicated Resident # 59 was assigned to her care and she was familiar with the resident's need. Nurse # 3 was unsure why resident was wearing a hospital gown and stated the resident sometimes pulled the bed spread off. Nurse stated it was the responsibility of both nurses and nurse aide to ensure the resident was properly dressed and his dignity maintained. During a continuous observation on 6/19/19 from 11:40 - 11:55 AM, the door to Resident # 59's room was open. Resident # 59 was observed	F 550	will be documented utilizing the "F550 Resident's Rights/Dignity/Exposure Audit Tool". Audits will be conducted Weekly x 4, Biweekly x 2 and Monthly x 1 for 3 months. DON will report findings of audits to QAPI Committee monthly x 3 months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 550	Continued From page 3	F 550		

from the room's doorway/hallway, lying in bed, wearing hospital gown that was raised above the chest, the lower half of the resident's body was not covered. The resident's brief was visible from the hallway. Observations revealed the privacy curtain was not drawn around the resident's bed. The maintenance director at 11: 55 AM observed the resident, pulled the privacy curtain and closed the door of the resident's room.

During an interview on 6/19/19 at 12:05 PM, the maintenance director indicated the resident needed the privacy as he was seen from the hallway. The maintenance director indicated, he had to close the door so that the resident could not be seen by others from the hallway and the resident's dignity was maintained.

During a continuous observation on 6/19/19 from 2:20 PM to 2:40 PM, the door to Resident # 59's room was open. Resident # 59 was observed from the room's doorway lying in bed, wearing hospital gown that was raised above the abdomen, the lower half of the resident's body was not covered. The resident's brief was visible from the hallway. Observations revealed the privacy curtain was not drawn around the resident's bed.

During an observation and interview on 6/19/19 at 2:40 PM, Nurse # 4 was observed adjusting Resident #59's bed spread and pulling the privacy curtain around the resident's bed. During the interview, Nurse # 4 stated she was the unit coordinator and was familiar with resident's care. Nurse #4 stated the privacy curtain should be drawn to provide privacy to the resident. Nurse # 4 stated the nurse aides were responsible to ensure the resident was properly dressed.

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F 550	Continued From page 4 During an interview on 6/20/19 at 9:47 AM, Nurse aide (NA#1) stated the resident was dressed in his clothes when they were available. NA #1 indicated the resident had very few clothes of his own. NA #1 stated the resident tended to remove his sheets and it was part of his behaviors. NA#1 indicated the resident was totally dependent on one-person assistance for ADL care. NA#1 stated the resident did not refuse care. On 6/21/19 at 4:25 PM, during an interview, Director of Nursing (DON) indicated that the resident's family did not provide extra clothes. The resident preferred to be in hospital gown most part of the days. The staff reported, he often removed his bed linens. The DON expected the staff to monitor resident's condition frequently, to make sure he appropriately used the bed linens and clothes, to provide assistance with ADL care, according to the plan of care and in a timely manner. The DON further stated the expectations were always to have the resident properly dressed and privacy provided to the resident.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		7/19/19

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F 584	Continued From page 5 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the tube feeding pump in a clean and sanitary condition for 1 of 1 sampled resident observed for tube feeding. (Resident # 59). Finding Included: Resident # 59 was readmitted to the facility on	F 584	Resident #59's Tube Feeding Pump was cleaned immediately. Current Residents receiving Tube Feeding via pump were reviewed on 6/20/19, pumps were inspected by DON/Central Supply Clerk for cleanliness and no deficient practice was noted.	

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F 584	Continued From page 6 4/23/19 with diagnoses that included hemiplegia affecting the left side, major depressive disorder, vascular dementia, aphasia, dysphagia, psychotic disorder and anxiety disorder. Resident # 59's most recent quarterly Minimum Data Set (MDS) dated 5/17/19, revealed Resident # 59 was non-verbal and rarely could make self-understood. The resident was severely cognitively impaired and needed extensive to total assistance of 1-2 people for activities of daily living (ADL). Resident was always incontinent of bowel and bladder. Resident received tube feeding as a source for nutrition. Resident # 59 was observed on 6/18/19 at 2:42 PM for tube feeding. The resident received continuous tube feeding with the formula and flushes hanging from the pole. The tube feeding pump had cream colored dried substance that resembled the formula hung on the pole, on the screen and base of the pump. An observations of Resident # 59's tube feeding pump on 6/19/18 at 11:15 AM and on 6/20/19 at 9:16 AM revealed the screen and base of the tube feeding pump had cream colored dried substance on it. During an interview with Nurse Aide (NA)# 1 on 6/20/19 at 9:47 AM, she indicated she does put the machine on hold mode when providing ADL care, however has not noticed the pump to be dirty. NA # 1 stated she does not clean the tube feeding pole or pump when it became dirty. During an interview with Nurse # 1 on 6/20/19 at 2:20 PM, he stated he had replaced Resident # 59's formula earlier today and had not noticed the	F 584	DON/ADON/Unit Coordinators provided in services to Licensed Nurses beginning 6/20/19 and will be completed by 7/15/19. Education will be part of new nurse orientation. Included in the in service was manufacturers recommendation for nursing on cleaning feeding pumps. DON/ADON/Unit Coordinators will randomly audit residents with feeding pumps for cleanliness. Audits will be documented utilizing the "F584 Tube Feeding Pump Cleanliness Audit Tool". Audits will be conducted Weekly x 4, Biweekly x 2, Monthly x 1 for 3 Months. Director of Nursing will report findings of audits to QAPI Committee monthly x 3 months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 584	Continued From page 7 tube feeding pump to be dirty. Nurse #1 indicated the nurses were responsible for keeping the tube feeding equipment clean. During an interview on 6/20/19 at 2:45 PM, the Director of Nursing (DON) stated it was the responsibility of the housekeeping staff to clean the tube feeding equipment. She stated It was her expectation that the nurses notified the housekeeping staff for any cleaning needs. During an interview with the Housekeeping staff #1 on 6/20/19 at 2:50 PM, she stated the floor and the tube feeding pole were cleaned of spills during daily room cleaning. The housekeeping staff further stated housekeeping does not clean any pump or equipment when these were in use by the resident or connected to the resident. During an interview on 06/21/19 10:01 AM, the Housekeeping Manager indicated the medical equipment were only cleaned by housekeeping staff when residents were discharged, or the resident was no longer using the equipment. He further indicated that the staff places the equipment for cleaning in the dirty linen room for the housekeeping staff to clean. The housekeeping manager stated his staff does not clean any equipment or pump while the resident was using it. On 6/21/19 at 5:25 PM, during an interview, the Administrator indicated that he expected the staff to monitor resident's needs and appearance, and to maintain equipment in a clean working condition.	F 584		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		7/19/19

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F 679	Continued From page 8 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program that met the individual interests and needs to enhance the quality of life for 1 of 1 sampled cognitively impaired residents reviewed for activities. (Resident #59). The findings included: Resident # 59 was admitted on 4/16/18 with diagnosis that included hemiplegia affecting the left side, major depressive disorder, vascular dementia, psychotic disorder and anxiety disorder. Review of Resident # 59's annual Minimum Data Set (MDS) assessment dated 2/19/19 revealed, the resident preference for customary routine and activities were indicated as family involvement in care discussions, listening to music, keeping up with news and participating in his favorite activities. Resident # 59's most recent quarterly MDS assessment dated 5/17/19, revealed the resident	F 679	Resident #59 is currently discharged to the hospital. Bedbound residents who reside in the facility have the potential to be affected by the alleged deficient practice. DON/ADON/Unit Coordinators/Activity Director completed an audit by 7/10/19 for bedbound residents to ensure they are receiving appropriate activities/sensory stimulation. DON provided education to Activity Director on F679, education included but not limited to: programs to support group and individual activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Education was completed on 7/10/19. DON/ADON/Unit Coordinators/Activity Director will randomly audit residents for	

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F 679	Continued From page 9 was readmitted on 4/23/18. Resident # 59 was assessed a having no speech and rarely could make self-understood. The resident was assessed as cognitively impaired and needed extensive to total dependence with 1-2 people assistance for activities of daily living (ADL). Resident was always incontinent of bowel and bladder. Resident# 59's revised care plan dated 5/17/19 indicated the resident was at risk for social isolation due to cognitive status. The resident's activity interests included outdoor sports, news on TV, contact with family, music, books on tape, people watching in the hall when in a wheelchair and wheelchair strolls in the facility. The Goals included having social stimulation daily with staff and responding with eye tracking or head nodding during interaction with activities. Interventions included were assistance with TV/ music operations, assistance to activity areas as needed, at least 3 x per week visit from activity staff or volunteers for conversation, reminiscing, reality orientation and offer wheelchair strolls in the facility. During an observation on 6/18/19 at 2:36 PM, Resident #59 was observed lying in bed. Resident was unable to communicate but could follow with his eyes during a conversation. The resident did not have a radio or music player in his room. There was a television playing in his room that was not clearly visible to him. The TV was shared between the resident and his roommate. During an interview with Resident # 59's roommate on 6/18/19 at 2:36 PM, the roommate indicated he usually plays the television on his	F 679	appropriate activities/sensory stimulation. Audits will be documented utilizing the "F679 Residents Receiving Appropriate Activities". Audits will be conducted Weekly x 4, Biweekly x 2, Monthly x 1 for 3 Months. Director of Nursing will report findings of audits to QAPI Committee Monthly x 3 Months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 679	Continued From page 10	F 679		

favorite channel and watches all his favorite programmers and episodes on it.

During an observation on 6/19/19 at 8:11 AM, Resident #59 was observed lying in bed with his eyes opened. There was no music playing in his room. The resident could not watch the TV as the roommate's privacy curtain was drawn between him and his roommate.

During an observations on 6/19/19 at 11:01 AM, Resident #59 was observed lying in bed and observing people in the hallway. There was no music playing in his room.

Observation on 6/20/19 at 9:40 AM revealed Resident#59 was observed lying in his bed. There was a music player on the side table near his head. No music was playing from the music player. Resident's roommate was watching TV; however, the resident could not watch it as the roommate's privacy curtain was drawn between the resident and his roommate. Resident# 59 was observing people in the hallway.

During an interview on 6/20/19 at 9:47 AM, Nurse aide (NA)#1 stated she had not observed Resident # 59 been taken to any activities or activity staff conducting any one on one activities for the resident. NA # 4 stated Resident # 59 was totally dependent with one person assist for ADL care. NA # 4 indicated she did talk to resident while care was provided as a stimulation to him.

During an interview on 6/20/19 at 2:45 AM, Nurse #1 stated he was not very familiar with the resident and was not sure if Resident # 59 was provided any activities the staff. Nurse #1 stated Resident #59 could not verbally communicate

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F 679	Continued From page 11	F 679		

and was total dependent on staff for activities of daily living.

During an interview on 06/21/19 at 3:00 PM, Nurse #2 stated she was not very familiar with the resident as she was a floater. Nurse #2 stated she was the assigned nurse for the resident twice this week. Nurse #2 stated she was not sure if resident was provided any activities by staff. She stated resident was non-verbal and was totally dependent on staff for ADL care.

Review of the "individual activity participation record" for March 2019 revealed Resident #59 had participated in music activity on 4th, 13th, 18th and 25th of the month; participated in reading activity on 1st, 8th, 14th, 19, 27th of the month. TV/ Music activity and staff visits were marked as provided for most of the days during the month.

Review of the "individual activity participation record" for April 2019 revealed Resident #59 had participated in music activity on 1st, 3rd, 5th, 10th and 29th of the month.; participated in reading activity on 4th, 8th, 17th, 25th of the month. TV/ Music activity and staff visits were marked as provided for most of the days in the month.

During an interview on 06/21/19 at 3:30 PM, the activity assistant stated Resident#59 had a radio and CD player in his room and gospel music was played sometimes. The activity assistant indicated the resident had a TV in his room and that was considered as stimulation for the resident. The activity assistant indicated, she was not aware the resident could not view the television when the privacy curtain was drawn, and that the TV was played per roommate choice

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F 679	Continued From page 12 of programs. The activity assistant also stated, the resident received stimulation daily during care that was provided by the nursing staff. She indicated the nurses and nurse aides would talk to the resident during care and treatment and that was staff daily stimulation. Activity assistant indicated, Resident # 59's "individual activity participation record" for March and April indicated the resident received these activities on a daily basis. Activity assistant stated the resident received room visits by a volunteer who read to the resident, however added these visits were random. She stated the calendar did not indicate a specific time for 1:1 activities. Activity assistant confirmed the resident did not attend any group activities nor had received any one to one visits from activity staff or volunteers this week. The activity assistant also confirmed that the resident was not brought to any group activity. The activity assistant stated the resident's activity participation documentation for May and June 2019 was incomplete and could not provide information on one to one activities that were provided to the resident. During an interview on 6/21/19 at 5:25 PM, the Administrator stated it was the expectation that the activity staff include resident's preferences in the activity assessment and provide activities as indicated in the care plan. The Administrator stated the activity participation records should be utilized to accurately reflect the resident participation and the one to one activities should be planned as care planned.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		7/19/19

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F 688	Continued From page 13 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to apply left hand palmar guard as written by the Occupation Therapist (OT) for 1 of 1 sampled residents with limited range of motion/contractures (Resident # 59). The findings included: Resident # 59 was admitted on 4/16/18 with diagnosis that included hemiplegia affecting the left side, major depressive disorder, vascular dementia, psychotic disorder and anxiety disorder. Review of the rehab to restorative transition record dated 5/7/19, which was referred by OT read in part "the goal of intervention - to decrease spasticity in left shoulder, elbow, hand and fingers and continue daily donning of left palmar guard	F 688	Resident #59 is currently discharged to the hospital. Residents who reside in the facility and have orders/referrals from therapy for palmar guards have the potential to be affected by the alleged deficient practice. DON/ADON/Unit Coordinators conducted an audit of residents with palmar guards to ensure application. Audit completed 7/10/19. DON/ADON/Unit Coordinators provided in services to nursing staff on 6/22/19 - 7/15/19. Education will be included in new nurse orientation. In service included: Importance of donning and doffing palmar guards, reasons for use, definitions and completion of active/passive ROM during care.	

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F 688	Continued From page 14 for contracture management. Activities to be performed with the resident - Donning the left palm guard daily; Doffing of left palmar guard in the evening. Frequency and Duration- Donning left palmer guard every morning; passive range of motion (PROM) left upper extremities 5 X week". The document indicated the restorative nurse aide (NA) was instructed in above functional maintenance program and could perform it with the resident as instructed. The document was signed by the OT and restorative care nurse aide (NA). Review of Resident # 59's most recent Minimum Data Set (MDS) dated 5/17/19, a quarterly assessment revealed the resident was readmitted on 4/23/19. Resident # 59 was assessed as cognitively impaired and needed extensive assistance to total dependent with 1-2 people for activities of daily living (ADL). The assessment was coded as resident having functional impairment with limited mobility of upper and lower extremities on one side. The review of the care plan for Resident #59 dated 5/17/19 revealed the resident was care planned for ADL, hemiplegia and limited mobility. The goals included: the staff will anticipate resident's daily needs, the resident's needs will be met by being neatly dressed and groomed, clean and odor free; the resident will maintain optimum status and quality of life within limitations imposed by hemiplegia. The interventions included: Applying left palmar guard in the morning and removing them in evening. staff to observe left hand for any skin breakdown and effective pain management prior to ADL activities. Range of motion (ROM) with am/pm daily care.	F 688	DON/ADON/Unit Coordinators will randomly audit application of palmar guards. Audits will be documented utilizing the "F688 Application of Palmar Guards Audit Tool". Audits will be conducted Weekly x 4, Biweekly x 2, Monthly x 1 for 3 Months. DON will report findings of audits to QAPI Committee Monthly x 3 Months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 688	Continued From page 15	F 688		

Review of the OT notes dated 5/17/19 read in part " patient tolerated ROM with grimace and tapping right upper extremity (RUE) in pain. Hand hygiene completed and palm protector redonned. "

Review of the OT notes date 5/18/19 read in part " Modified palm guard removed, hand hygiene completed".

Review of the OT notes dated 5/20/19 read in part " Patient observed in bed, holding his palm protector but he had removed it. Skin checked and no observed issues. "

Review of the OT discharge summary dated 5/20/19 revealed resident received OT services from 5/7/19 - 5/20/19. Short term goal indicated " Patient will safely wear a palmar guard on left hand for up to 2 hours with minimal signs and symptoms of redness, swelling, discomfort or pain".

Review of the Nurse Aide (NA) care guide for Resident # 59 read in part - " Dressing/ Splint care - Apply left palmer guard every AM and remove in PM. Observe left hand for any skin breakdown and report to MD if noted. If resident removes palmar guard, reapply if he will allow. Remove left palmar guard in the evening ".

An observation of Resident # 59 on 6/18/19 at 3:01 PM. Resident # 59 was in bed and observed with contractures to left hands. Resident did not have palmar guard to his left hand.

An observation of Resident # 59 on 6/19/19 at 11:01 AM. Resident # 59 was in bed and no palmar guard was observed on his left hand.

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F 688	Continued From page 16	F 688		

An observation of Resident # 59 on 6/20/19 at 9:00 AM. Resident # 59 was in lying in bed. palmar guard was observed on the side table in resident's room.

During an interview on 6/20/19 at 9:00 AM, the Occupation therapist #1 (OT) indicated Resident #59 was not currently treated by the therapy department for his hand contractures. OT#1 stated the resident had palmar guards that need to be placed to his palm in the morning and removed when hand hygiene was provided. OT #1 stated resident was under restorative care for ROM and contracture care.

During an interview on 6/20/19 at 9:35 AM, the restorative care nurse aide (NA) indicated Resident # 59 was on her case load. The restorative care NA stated Resident # 59 participated in ROM exercises for upper and lower extremities 3-5 times a week. The restorative care NA further stated the resident's palmar guards/ protectors were discontinued by therapist as the resident had refused and the palmar guards were not working well.

During an interview on 6/20/19 at 9:47 AM, Nurse Aide (NA) # 1 stated Resident # 59 was total dependence with one-person assistance for ADL care. NA # 1 stated, she had never applied any palmar guard for the resident's left hand and was not aware a palmar guard was needed to his left hand. NA stated the resident's care instructions were in a book near the nursing station. NA #1 indicated, Resident # 59 had contractures to his left hand, however was not sure if the resident had any palmar guard.

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F 688	Continued From page 17	F 688		

On 6/20/19 at 9:54 AM, observed NA#1 enter Resident# 59's room. NA #1 noticed the palmar guard on the side table and placed it on the resident's hand. Upon interview the NA#1stated, she put the palmar guard on as she noticed them on the side table.

During an interview on 6/20/19 at 2:25 PM, Nurse #1 stated he was unsure if resident had palmar guards to his hands, and unsure about the duration of wears and when these were removed. Nurse #1 indicated he had not seen any order in the Medication administration record (MAR) and that palmar guard care and instructions should be with the restorative care NA or with therapy.

During an interview on 6/21/19 at 9:35 AM, the Occupation therapist #2 (OT) indicated Resident #59 was not currently treated by the therapy department for his hand contractures. The OT # 2 indicated Resident # 59 was discharged from therapy services on 5/20/19 to restorative care with recommendations for palmar guards to the resident's left hand daily in the morning except when hand hygiene was provided. The OT #2 indicated the restorative care NAs were responsible to provide palmar guards daily after hand hygiene and were educated on this. The OT#2 indicated the discharge instructions were provided to the restorative care NAs and the Director of Nursing (DON). The OT # 2 further indicated the DON had included them in Resident # 59's daily care routine.

During an interview on 6/21/19 at 11:39, the Director of Nursing (DON) indicated Resident# 59's therapy discharge instructions were included in the resident's daily NA care guide and the NAs

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F 688	Continued From page 18 were trained accordingly. The DON stated it was her expectation that the restorative care NA and NA apply the palmar guard as indicated in the therapy discharge instructions. During an interview on 6/21/19 at 05:25 PM the Administrator stated it was his expectation that the staff followed the recommendations of therapy department related to palmar guards or any splints that residents needed for their contractions.	F 688		
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 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	F 761		7/19/19

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F 761	Continued From page 19 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove three expired insulin pen injectors, stored in 1 of 3 medication administration carts (200 hall). Findings Included: On 6/19/19 at 9:00 AM, observation of the medication administration cart on 200 hall with Nurse #5 revealed the following expired medications were found: two Novolog Flex Pens (insulin), 100 units/ml (units per milliliter), 3 ml. Per the label on the pens, one Novolog was opened on 5/3/19 and second Novolog was opened on 5/19/19. Review of the manufacturer ' s literature/information (or package insert) recommended to discard the Novolog 28 days after opening, which would have been on 5/31/19 and 6/16/19 respectively; one Humalog Pen, 100 units/ml, 3 ml. Per the label on the pen, the Humalog was opened on 5/3/19. Review of the manufacturer ' s literature/information (or package insert) recommended to discard the Humalog 28 days after opening, which would have been on 6/16/19. On 6/19/19 at 9:15 AM, during an interview, Nurse #5 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that the insulin pens were opened. The nurse had not check the expiration date on all insulin pens in her medication administration cart at the beginning of her shift.	F 761	Expired insulin pens were removed from A Cart immediately. All other medication carts were inspected on 6/19/19 by ADON/Unit Coordinators and no expired insulin pens were noted. DON/ADON/Unit Coordinators provided in services to Licensed Nurses beginning 6/20/19 and will be completed by 7/15/19. Education will be part of new nurse orientation. In service included manufacturer's guidelines for storage stability, checking insulin pens for expiration before administration, and removal from medication cart immediately. DON/ADON/Unit Coordinators will randomly audit insulin pens for expiration. Audits will be documented utilizing the "F761 Insulin Pen Audit Sheet". Audits will be conducted Weekly x 4, Biweekly x 2, Monthly x 1 for 3 Months. DON will report findings of audits to QAPI Committee Monthly x 3 Months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 761	Continued From page 20 On 6/19/19 at 10:25 AM, during an interview, Nurse #6 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. On 6/19/19 at 12:00 PM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check all the medications in medication administration carts for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 812	All unlabeled or expired foods were	7/19/19

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F 812	Continued From page 21 facility failed to label and date food items in 1 of 2 reach in refrigerators, failed to discard foods stored past their expiration or use-by date in 1 of 2 reach in refrigerators, 2 of 2 nourishment refrigerators and bread stored in the kitchen's dry storage area. Finding included: 1. An observation of the kitchen reach-in refrigerator on 6/18/19 at 9:25 AM revealed, food wrapped in an aluminum foil. There was no label on the aluminum foil. Also, observed stored in this refrigerator was a plastic container containing red colored food that resembled a sauce. The container's label read " tomato sauce" with a use by date of " June 11". During an interview with the dietary manager on 6/18/19 at 9:28 AM, he stated that all food should be labelled when placed in the refrigerator. The dietary manager indicated the aluminum foil contained leftover fish that should have been discarded. He further stated the cooks should be using the food within the use by date. The dietary manager indicated the kitchen manager was responsible to check for labelling and discard any food that was passed the use by date. During an interview on 06/20/19 at 1:38 PM, the kitchen manager stated he usually checks the reach in refrigerator for any food that needs to be used before the use by date, discard the food as needed and also checks for food / leftovers were labelled correctly. The kitchen manager indicated he was busy on the morning of 6/18/19 and did not have an opportunity to check the reach in refrigerators.	F 812	removed immediately. The facility stores food in accordance with regulatory and facility policy. Nourishment Room refrigerators and kitchen food storage areas were audited by dietary and regional managers for any other expired or unlabeled items on 6/18/19, no deficient practice was noted. Dietary and Regional Managers provided re-education to dietary staff on 6/18/19. Education will be included in new hire orientation. Education included: marking, dating, wrapping and pulling expired foods according to regulatory and facility policy. Dietary Managers will randomly audit nourishment rooms and kitchen storage areas for unlabeled and expired items. Audits will be documented utilizing the "F812 Food Storage Audit" Tool. Audits will be conducted Weekly x 4, Biweekly x 2, Monthly x 1 for 3 months. Dietary Manager will report findings of audits to QAPI Committee Monthly x 3 Months for review and recommendations. The DON is responsible for ensuring this POC is implemented.	

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F 812	Continued From page 22	F 812		

During an interview with on 06/20/19 at 1:43 PM, the dietary cook stated, he usually labels the food before placing them in the reach in refrigerator, uses leftovers within the indicated use by date and any food past use by date was discarded. The dietary cook indicated he was unsure who had placed the left over without labeling them and why the food was not discarded past use by date.

2. Observations of the facility's two nourishment refrigerators revealed the following concerns with foods being stored in these refrigerators that was past their expiration or use by dates:

a. An observation of the Station 1 nourishment refrigerator on 6/18/19 at 9:30 AM revealed 5 - 8 oz whole milk cartons with expiration date "6/13/19 ".

b. An observation of the Station2 nourishment refrigerator on 6/18/19 at 9:38 AM revealed, 3 - 8 oz 2% milk carton with the expiration date "6/13/19". A sandwich with a label " egg sandwich", prep date "6/4/19' and use by date "6/11/19". A sandwich with a label " Pimento cheese sandwich" use by date "6/13/19".

During an Interview on 6/18/19 at 9:31 AM, the dietitian stated the dietary staff were responsible to rotate food and remove any food that was expired.

During an interview on 6/20/19 at 1:30 PM, the dietary manager stated the dietary staff placed snacks in the nourishment refrigerator twice a day and usually checks and discards any expired food. The dietary manager further stated it was the responsibility of the kitchen manager to check

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the nourishment refrigerators daily in the morning. The dietary manager indicated the kitchen manager was not able to complete his inspection that morning.

During an interview on 6/20/19 at 1:38 PM, the kitchen manager stated the nourishment refrigerators were checked for any expired food daily and he had not noticed them earlier.

During an interview on 6/20/19 at 1:42 PM, the dietary aide stated she usually replaces snacks, sandwiches in the nourishment refrigerator twice a day. The dietary aide further stated the snacks were placed in the refrigerator daily around 12:30 - 1 PM and before the end of the shift around 8:30 pm. The dietary aide stated she was unaware the nourishment refrigerator had expired food. The dietary aide indicated the snacks and milk were rotated and food that has passed the expiration date or the use by date were discarded. She further indicated cartons of milk were not placed daily but were placed occasionally in the nourishment refrigerator.

3. Observation of the bread rack in the kitchen's dry storage area on 6/18/19 at 9:20 AM revealed 3 bags containing 12 hamburger buns each with use by date " June 15th 2019 ", 3 bags containing 12 hamburger buns each with use by date "June 13th 2019", 3 loafs of Marble swirl rye bread with use by date "June 15th 2019" and 3 loaves of white bread with use by date "June 15th 2019".

During an interview on 6/18/19 at 9:22 AM, the dietary manager stated that he and the kitchen manager were responsible to check the bread. The dietary manager further indicated, he and the kitchen manager had overlooked the bread

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F 812	Continued From page 24 products found with expired use by dates and did not check all the bread racks. On 6/21/19 at 5:25 PM, during an interview, the Administrator stated it was his expectation that the foods were labelled and discarded when expired or passed use by date.	F 812		