| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345284 | A. BUILDING _____ B. WING _____ | C 07/25/2019 |

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| THE OAKS | 901 BETHESDA ROAD WINSTON SALEM, NC 27103 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 7/21/19 through 7/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # HKLT11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification with complaint investigation survey was conducted from 7/21/19-7/25/19. 17 of the 32 complaint allegations were substantiated resulting in deficiencies F550, F561, F624, F677 and F686. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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.<br><br>§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. | F 550 | | 8/22/19 |

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

Electronically Signed | 08/19/2019

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| F 550 | Continued From page 1<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident, family and staff interviews and record review, the facility failed to provide care in a manner to maintain a resident's dignity by not providing a privacy cover for a urinary catheter drainage bag for 1 of 4 residents (Resident #263) reviewed for urinary catheters.<br><br>Findings included:<br><br>Resident #263 was admitted to the facility on 7/11/19 with diagnoses that included, in part, neuromuscular dysfunction of bladder and retention of urine.<br><br>A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/18/19 revealed Resident #263 was cognitively intact and had an indwelling urinary catheter.<br><br>A review of the care plan updated 7/17/19 | F 550 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F550 Resident Rights/Exercise of Rights<br>Corrective Action:<br>Resident #263. A privacy cover for the urinary catheter drainage bag was provided to maintain resident's dignity and privacy on 7/23/19. Resident #263 | |

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| F 550 | Continued From page 2<br>included the use of an indwelling suprapubic catheter with an intervention to "keep catheter bag covered adequately to promote dignity."<br><br>On 7/21/19 at 1:10 PM an observation of Resident #263 revealed she was in bed in her room. The door to the resident's room was opened to the hallway. The resident's urinary catheter drainage bag was uncovered, contained urine, hung on the side of the bed and was visible from the hallway.<br><br>On 7/22/19 at 3:16 PM an observation of Resident #263 revealed she was in bed in her room. The door to the resident's room was opened to the hallway. The resident's urinary catheter drainage bag was uncovered, contained urine, hung on the side of the bed and was visible from the hallway.<br><br>On 7/23/19 at 2:32 PM an observation of Resident #263 revealed she was in bed in her room. The door to the resident's room was opened to the hallway. The resident's urinary catheter drainage bag was uncovered, contained urine, hung on the side of the bed and was visible from the hallway.<br><br>On 7/23/19 at 2:33 PM an interview was completed with Nurse #1. She stated the protocol for catheter drainage bags was that they were kept covered when a resident was not in their room.<br>Nurse #1 said when a resident was in their room the drainage bag did not necessarily need a cover.<br><br>On 7/23/19 at 3:13 PM an interview was completed with Resident #263 during which the | F 550 | discharged 8/3/19.<br>Identification of other residents who may be involved with this practice:<br>All residents requiring the use of a urinary catheter drainage bag, have the potential to be affected by this practice. A complete audit of all residents requiring a urinary catheter drainage bag was done to ensure that resident's dignity and privacy was maintained by providing a privacy cover for the urinary catheter drainage bag. The Director of Nursing and Registered Nurse Unit Managers completed this audit on 8/16/19 for all nursing stations. Six residents were identified requiring a privacy cover for the urinary catheter drainage bag. All six residents have a privacy cover for the urinary catheter drainage bag to maintain their dignity and privacy.<br>Systemic Changes:<br>All Full Time and Part Time and PRN (Registered Nurses, Licensed Practical Nurses, Medication Tech's, Nursing Assistants) will be educated on the following by the Director of Nursing. Education began on 8/19/19. All residents who require a urinary catheter drainage bag, must have a privacy cover to maintain their dignity and privacy at all times. 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. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that | |

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| F 550 | Continued From page 3<br>resident stated she didn't care if other people saw the drainage bag from the hallway.<br><br>On 7/24/19 at 10:44 AM an interview was completed with Resident #263's family member. He stated since the resident had been hospitalized and then admitted to the facility he noticed she had some issues with her memory and was not at her cognitive baseline. The family member said when Resident #263 was at baseline with cognition and memory she preferred the drainage bag be covered in order to protect her dignity and privacy.<br><br>On 7/23/19 at 3:08 PM an interview was completed with the Director of Nursing (DON). She stated drainage bags were supposed to be covered to provide privacy and dignity, particularly when the drainage bag faced the doorway where it could be viewed by others who walked by the room. The DON said she had educated staff in the past about catheter care and the education included covering the drainage bags. She further stated the nurse went into the resident's room daily and performed catheter care. The DON said she expected catheter drainage bags be covered at all times. | F 550 | 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. 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. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. 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. Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br>This in service will be completed by 8/22/2019. Any nurses, nursing assistants, med tech's (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. | |

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| F 550 | Continued From page 4 | F 550 | Monitoring:<br>To ensure compliance, The Director of Nursing and or Unit Manager will observe 5 residents who require a urinary catheter drainage bag to ensure that resident's dignity and privacy is maintained by providing a privacy cover for the urinary catheter drainage bag. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the Weekly Quality of Life/Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by: | F 554 | | 8/22/19 |

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| F 554 | Continued From page 5<br>Based on observations, resident and staff interviews, and record review, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sample resident (Resident #44) who was observed to have a medication at bedside.<br><br>The findings included:<br><br>Resident #44 was admitted to the facility on 8/23/16. His cumulative diagnoses included chronic obstructive pulmonary disease (COPD).<br><br>A review of Resident #44 ' s most recent Minimum Data Set (MDS) was an annual assessment dated 5/16/19. The MDS assessment revealed the resident had intact cognitive skills for daily decision making. He required supervision only for eating, limited assistance for locomotion on the unit and for toileting, and extensive assistance from staff for bed mobility, transfers, locomotion off the unit, dressing, and personal hygiene.<br><br>A review of the resident ' s current Care Plan (not dated) was completed. Resident #44 ' s care plan did not address the self-administration of medications.<br><br>A review of Resident #44 ' s current physician orders included a medication order for 100-62.5-25 micrograms per inhalation of Trelegy Ellipta to be given as one inhalation orally one time a day for COPD. The medication order included a notation to rinse mouth after use and spit out. Trelegy Ellipta is a dry powder inhaler containing a combination of three active ingredients (fluticasone, a corticosteroid; umeclidinium, a type of bronchodilator to open | F 554 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F554 Resident Self-Admin Meds-Clinically Approp<br>Corrective Action:<br>Resident #44. Resident was offered an opportunity to self-administer his medication during assessment. Resident indicated no desire to self-administer medications, this was documented in the appropriate place in the resident's electronic medical record, and the resident was deemed to have deferred this right to the facility.<br>Identification of other residents who may be involved with this practice:<br>All cognitively intact residents with a BIMS of 13 or greater, have the potential to be affected by this practice. Each cognitively intact resident was offered an opportunity to self-administer his or her medications during review by the facility's interdisciplinary team (Director of Nursing, Unit Managers, Minimum Data Set [MDS] Coordinators, and Staff Nurses) on 8/16/2019. If the cognitively intact resident indicated no desire to self-administer medications, this was documented in the | |

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| F 554 | Continued From page 6<br>the airways; and, vilanterol, a long-acting bronchodilator). The current physician orders did not include an order for the resident to self-administer any of his medications.<br><br>A review of Resident #44 ' s electronic medical record revealed no assessments were completed for the self-administration of medication.<br><br>An observation was conducted on 7/21/19 at 10:47 AM as Resident #44 was lying in bed watching his television. An inhaler medication was observed on the TV table placed next to the bed and within reach of the resident. Resident #44 was asked if the inhaler could be inspected, permission was given to do so, and the inhaler was identified as a Trelegy Ellipta inhaler. Upon inquiry, the resident stated he put the inhaler on the table after he was done using it. He reported the inhaler was always kept there. A pharmacy auxiliary label placed on the inhaler read, "Rinse mouth after use."<br><br>Additional observations were made of the Trelegy Ellipta inhaler placed on the table at Resident #44 ' s bedside on 7/21/19 at 12:50 and on 7/21/19 at 1:35 PM.<br><br>An interview was conducted on 7/21/19 at 3:15 PM with Resident #44. The Trelegy Ellipta inhaler was observed on the TV table next to the bed at the time of the interview. Upon inquiry, Resident #44 reiterated the inhaler was always kept by his bedside and reported he administered the medication himself. Upon further inquiry, the resident stated he used the inhaler earlier that morning. Resident #44 reported he typically used the inhaler in the mornings and "sometimes" at night. When asked if he did anything special | F 554 | appropriate place in the resident's electronic medical record, and the resident was deemed to have deferred this right to the facility. If the cognitively intact resident desired to self-administer medications an assessment was conducted by the interdisciplinary team to determine the resident's ability to self-administer medications. The results of the interdisciplinary team assessment are recorded on the Medication Self Administration Assessment, which is in the resident electronic health record. If the cognitively intact resident demonstrated the ability to safely self-administer medication, the physician was notified and a further assessment of the safety of bedside medication storage was conducted. This was completed by 8/16/2019. The Director of Nursing, Unit Manager and MDS Coordinators observed all residents room to ensure that there were no medications found at the bedside or room that were not authorized for bedside storage. No an authorized medications were observed in the resident's room or bed side. This observation was completed on 8/16/2019.<br>Systemic Changes:<br>All Full Time and Part Time and PRN (Registered Nurses, Licensed Practical Nurses, Medication Tech's, and Nursing Assistants) will be educated on the following by the Director of Nursing. Education began on 8/19/19. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized | |

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| F 554 | Continued From page 7 | F 554 | | |

after using the inhaler, he stated he did not. When asked if he rinsed his mouth and spit out the water after using the Trelegy Ellipta inhaler, the resident stated he did not, but "could." The resident noted that "sometimes" he would have some water to drink after using the inhaler.

Additional observations were made of the Trelegy Ellipta inhaler placed on the table at Resident #44 ' s bedside on 7/22/19 at 9:12 AM and on 7/23/19 at 8:20 AM.

Accompanied by the facility ' s Director of Nursing (DON), an observation was made on 7/23/19 at 8:25 AM of the Trelegy Ellipta inhaler on Resident #44 ' s bedside table and placed within reach of the resident. The DON picked up the inhaler and explained to the resident she would need to contact his physician to get approval for him to have this medication by his bedside.

An interview was conducted on 7/23/19 at 8:27 AM with the DON. During the interview, observations of the Trelegy Ellipta inhaler kept at the resident ' s bedside were discussed, along with information obtained via interviews conducted with the resident.

An interview was conducted on 7/23/19 at 1:29 PM with the resident ' s Medical Doctor (MD). During the interview, the observations of the Trelegy Ellipta inhaler at Resident #44 ' s bedside and his reported self-administration of the medication were discussed. Upon inquiry as to whether he had been asked if it was clinically appropriate for the resident to self-administer the Trelegy Ellipta inhaler, the physician stated he did not believe so. The MD stated he did not believe keeping a medication at bedside for

medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary. Each cognitively intact (BIMS of 13 or greater) resident is offered an opportunity to self-administer his or her medications on admission /readmission and during quarterly review by the facility's interdisciplinary team (Director of Nursing, Unit Managers, Minimum Data Set [MDS] Coordinators, and Staff Nurses). If the cognitively intact resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's electronic medical record, and the resident is deemed to have deferred this right to the facility. If the cognitively intact resident desires to self-administer medications an assessment is conducted by the interdisciplinary team to determine the resident's ability to self-administer medications. The results of the interdisciplinary team assessment are recorded on the Medication Self Administration Assessment, which is in the resident electronic health record. If the cognitively intact resident demonstrates the ability to safely self-administer medication, the physician is notified and a further assessment of the safety of bedside medication storage is conducted. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer using the conditions set forth in the policy and procedures. When

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| F 554 | Continued From page 8<br>self-administration without a physician ' s order was in compliance with the facility ' s policy.<br><br>A telephone interview was conducted on 7/24/19 at 12:00 PM with the Nurse Practitioner (NP) who helped to care for Resident #44. During the interview, the observations of the Trelegy Ellipta inhaler at Resident #44 ' s bedside and his reported self-administration of the medication were discussed. The NP stated she was not aware the resident was keeping an inhaler at bedside for self-administration.<br><br>An interview was conducted on 7/24/19 at 4:16 PM with the DON in regards to the resident's self-administration of medication and the Trelegy Ellipta inhaler kept at bedside. During the interview, the DON stated the resident was upset about the inhaler being taken away from him by staff. The DON reported the potential for Resident #44 ' s self-administration of the inhaler would be assessed and discussed further by the interdisciplinary team (IDT), in conjunction with the MD. | F 554 | the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. The resident requests each dose from the medication nurse, who provides the medication to the resident in the unopened package for the resident to self-administer. The nurse then records such self-administration on the EMAR.<br>This in service was completed by 8/19/2019. Any nurses, nursing assistants, med tech's (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and or Unit Manager will observe 5 residents rooms to ensure that No an authorized medications are in the resident's room or bed side. The Director of Nursing and or Unit Manager will review 5 cognitively intact (BIMS of 13 or greater) residents ( new admissions/readmissions) electronic medical record and ensure that documentation indicates that facility offered an opportunity to self-administer his or her medication on admission/readmission per facility policy | |

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| F 554 | Continued From page 9 | F 554 | and procedures. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee/Quality of Life meeting by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>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.<br><br>§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. | F 561 | | 8/22/19 |

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| | 345284 | A. BUILDING _____ B. WING _____ | C 07/25/2019 |

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| THE OAKS | 901 BETHESDA ROAD WINSTON SALEM, NC 27103 |

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| F 561 | Continued From page 10<br><br>§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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to honor a resident's choice and provide showers as scheduled for 1 of 5 residents (Resident #265) reviewed for choices.<br><br>Findings included:<br><br>Resident #265 was admitted to the facility on 7/8/19 with diagnoses that included, in part, hypertension and arthritis.<br><br>A review of the comprehensive Minimum Data Set (MDS) assessment dated 7/15/19 revealed Resident #265 was cognitively intact. He required physical help for bathing.<br><br>A review of the care plan updated 7/11/19 revealed a problem of activities of daily living (ADL) self-care performance deficit. An intervention included staff assistance with personal hygiene. | F 561 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F561 Self-Determination<br>Corrective Action:<br>Resident #265: Resident was offered a shower. Shower was provided to honor resident's choice.<br>Identification of other residents who may be involved with this practice:<br>All residents have the potential to be affected by this practice. On 8/15/2019 to | |

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| F 561 | Continued From page 11<br><br>On 7/22/19 at 9:03 AM an interview was completed with Resident #265 during which he stated, "I keep telling them I want to take a shower but have only had one shower." Resident #265 said he had been at the facility for approximately two weeks and had only received one shower.<br><br>A review of the medical record revealed Resident #265 was scheduled for showers on Tuesday and Friday evenings (3-11 PM shift). Further review of the medical record documentation revealed Resident #265 received a shower on 7/9/19 (Tuesday) and 7/12/19 (Friday). No shower was documented to have been provided on 7/16/19 or 7/19/19.<br><br>On 7/25/19 at 11:26 AM an interview was completed with Nurse Aide (NA) #3. She stated she worked with Resident #265 on 7/16/19 and recalled that she gave him a shower. NA #3 said she had not documented the shower in the computer kiosk but told the nurse that she gave a shower to Resident #265.<br><br>On 7/24/19 at 9:41 AM an interview was completed with Resident #265. He said he was not offered and did not receive a shower on the prior evening (Tuesday) as scheduled on 7/23/19.<br><br>A review of the medical record revealed Resident #265 refused a shower on 7/23/19.<br><br>On 7/24/19 at 3:26 PM an interview was completed with NA #2. She stated she worked with Resident #265 on 7/23/19 from 3:00-11:00 PM. She said the resident was on the schedule for a shower but a shower wasn't given. NA #2 | F 561 | 8/16/2019 all Kardex' s (this is a shortened version derived from the care plan that identifies key care needs for the residents) were reviewed to ensure that a shower schedule for each resident was in place and appropriate by Minimum Data Set Coordinators, Unit Manager and Director of Nursing. All resident's Kardex are accurate and appropriate. On 8/19/2019 the Director of Nursing, Unit Managers, Minimum Data Set coordinators interviewed all alert and oriented residents ( BIMS of 13 or greater) to ensure that they received a shower per schedule or as requested. All residents interviewed indicated that they received a shower per schedule or as requested. On 8/20/2019 the Director of Nursing, Unit Managers, Minimum Data Set coordinators observed all other residents ( BIMS of 12 or less) and reviewed electronic documentation for showers in the electronic medical record to ensure that they received a shower per schedule or as required. All observed residents were noted to have received a shower per schedule or as requested. Any resident who did not received a shower, had appropriate supporting documentation in the electronic medical record indicating why they did not shower and also that resident representative was notified. This observation was completed on 8/21/2019.<br>Systemic Changes:<br>All Full Time and Part Time and PRN (Registered Nurses, Licensed Practical Nurses, Medication Tech's, and Nursing Assistants) will be educated on the following by the Director of Nursing. | |

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|---|---|---|---|---|
| F 561 | Continued From page 12<br>said she thought she went in to Resident #265's room and offered a shower but could not remember if the resident answered yes or no. NA #2 reported she then left Resident #265's room and had not followed up with him and asked if he "really wanted one."<br><br>On 7/25/19 at 11:11 AM an interview was completed with the Director of Nursing (DON). She said residents were typically scheduled for showers twice a week. She said Resident #265 had a wound with a dressing on it and in order to maintain the dressing she thought it would be a better idea to switch his shower time to the day shift when he could receive a shower before wound care was done. The DON further said she expected if a resident was scheduled for a shower that the NA offered to provide a shower on the scheduled shower day. | F 561 | Education began on 8/19/19. Each 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. Each resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. Each resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. Each resident has a choice of how many times a week they can take a shower or bath. Each resident has a right to receive a shower or a bath per plan of care.<br>The nurse aide assigned to each unit will be required to document in the residents electronic medication record that the resident received shower as scheduled or as requested. The Nurse aide will notify the nurse assigned if a resident refuses to have their scheduled shower. The nurse will talk with the resident and if the resident still refuses, the nurse will notify resident's responsible party and document in the electronic medical record.<br>• You are required to review the kardex of all residents assigned to your care prior to the beginning of each shift to identify care needs of the resident.<br>• If you do not see a kardex then consult with your nurse for further care instructions.<br>• You should always follow the plan of care for the residents as outlined on the | |

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|---|---|---|---|---|
| F 561 | Continued From page 13 | F 561 | kardex. If the resident's condition has changed, you feel that the plan is unsafe, or the resident refuses to follow the plan then you should notify the nurse for additional guidance regarding care.<br>• To access the kardex you can click on the resident's name in the electronic health record and click on the kardex brick.<br>This in service will be completed by 8/22/2019. Any nurses, nursing assistants, med tech's (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and or Unit Manager will interview 5 alert and oriented (BIMS of 13 or greater) residents each week to ensure that they are receiving their showers as scheduled or as requested. The Director of Nursing and or Unit Manager will observe 5 non interviewable residents and also review the electronic documentation for showers each week to ensure that they are receiving their showers as scheduled or as required. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports | |

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| F 561 | Continued From page 14 | F 561 | will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 584 SS=B | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. | F 584 | | 8/22/19 |

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| F 584 | Continued From page 15<br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and resident and staff interviews, the facility failed to maintain a clean environment as evidenced by a). dirty windows in the main dining room and beside the door to the courtyard on 300 hall, b). dirty floors in 3 of 7 resident rooms (Rooms 304, 308 and 414), c). cobwebs behind the door and dust on the overbed light fixture in 1 of 7 resident rooms (Room 414) and d). a dirty pressure reducing boot for 1 of 7 residents (Resident #106) reviewed for pressure ulcers.<br><br>The findings included:<br><br>a). An observation on 7/21/19 at 12:30 PM of the windows beside the door to the courtyard on the 300 hall revealed poor visibility out of the windows | F 584 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F584 Safe/Clean/Comfortable/Homelike Environment<br>Corrective Action:<br>Main dining room: Windows cleaned | |

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| F 584 | Continued From page 16<br>due to excessive build up of dirt. During a Resident Council Meeting conducted during the survey on 7/23/19 at 3:15 PM, Resident #75 stated the windows in the dining room were dirty. An observation made at that time revealed several of the windows in the main dining room had a white residue on a large portion of the window.<br><br>b). An observation on 7/21/19 at 12:37 PM of room 304 revealed built up dirt on the floor and noticeable darkened area on the floor at the threshold and extending into the room.<br><br>An observation on 7/24/19 at 10:10 AM and on 7/25/19 at 2:45 PM of room 304 revealed the floor remained dirty with built up dirt and a noticeable darkened area on the floor at the threshold and extending into the room.<br><br>An observation on 7/21/19 at 12:48 PM of room 308 revealed a lancet and a pile of dirt in the corner of the room behind the door. The floor of the room was observed to be dirty and dull with a noticeable darkened area on the floor at the threshold and extending into the room.<br><br>An observation on 7/23/19 at 8:11 AM and 7/25/19 at 2:45 PM of room 308 revealed the lancet was still observed in a pile of dirt behind the door, and the floor of the room was still dull and dirty with a noticeable darkened area on the floor at the threshold and extending into the room.<br><br>An observation on 7/21/19 at 11:53 AM of room 414 revealed the floor had a dried, yellowish substance observed on the right side of the room upon entering. | F 584 | Door to the courtyard on 300 hall: Window cleaned<br>Rooms 304, 308 and 414: Floors cleaned, stripped and waxed.<br>Room 414: Cobweb cleaned behind door and overbed light fixture cleaned<br>Resident #106: Pressure reducing boot cleaned.<br>Identification of other residents who may be involved with this practice:<br>All residents have the potential to be affected by this practice. On 8/15/2019 to 8/22/2019 all windows, all overbed light fixtures, and all pressure reducing boots were cleaned. This will be completed by 8/22/2019. On 8/16/19 Environmental Services Director and Administrator audited all resident rooms to identify floors in need of stripping and waxing. On 8/19/19 a schedule was put in place to continue stripping, and waxing remaining floors over the next 2 months.<br>Systemic Changes:<br>All Full Time and Part Time and PRN , environmental services staff ( housekeeping and maintenance) will be educated on the following by the Administrator. All windows and floors are expected to be clean. 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; A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and | |

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|---|---|---|---|---|
| F 584 | Continued From page 17<br>An observation on 7/22/19 at 1:30 PM and 7/25/19 at 2:45 PM of room 414 revealed and the floor was still observed to have a dried, yellowish substance on the right side of the room upon entering.<br><br>c). An observation on 7/21/19 at 11:53 AM of room 414 revealed multiple spider webs behind the door from the ceiling to the floor and a visible layer of dust located on the overbed light of 414A.<br><br>An observation on 7/25/19 at 3:45 PM of room 414 revealed the spider webs remained behind the door of the room, the overbed light was still covered with a layer of dust.<br><br>d). An observation on 7/22/19 at 8:41 AM revealed Resident #106 wearing a pressure reducing boot to her foot that had a large reddish brown stain to the inside of the right side of the boot.<br><br>An observation on 7/24/19 at 2:43 PM revealed the large reddish brown stain remained to the inside of the right side of the boot.<br><br>On 7/25/19 at 1:38 PM, an interview was conducted with NA#1. NA#1 stated she didn ' t notice the stained area to Resident #106 ' s boot. NA #1 was unsure if the boot could be laundered and stated she would ask the treatment aid if there was another one that could be used.<br><br>On 7/25/19 at 2:45 PM, an interview was conducted with the housekeeper. She stated she worked day shift through the week and every other weekend. She stated that the daily room cleaning includes dusting, sweeping, mopping, cleaning the bathroom and emptying the trash. | F 584 | 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. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Clean bed and bath linens that are in good condition; Private closet space in each resident room, Adequate and comfortable lighting levels in all areas, Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81F; and For the maintenance of comfortable sound levels. Education began on 8/19/19. This in service will be completed by 8/22/2019. Any environmental services staff (housekeeping and maintenance) (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Administrator and or Director of Nursing will observe 5 resident’s rooms, hallways and dining room to ensure that the floors, overbed light fixture and windows are clean. The Director of Nursing will observe 5 | |

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| F 584 | Continued From page 18<br>The housekeeper accompanied the surveyor on a tour of rooms 304, 308 and 414. She stated she hadn ' t gotten to room 414 yet and she was off the day before. She stated the dirt and lancet behind the door in room 308 should be removed during the room cleaning. She stated the dirt on some of the floors was stuck on and most of the floors needed to be stripped and waxed.<br><br>On 7/25/19 at 3:05 PM, an interview was conducted with the Housekeeping Director. She stated sweeping, mopping and dusting were all part of daily room cleaning. She stated she did spot checks of the rooms but didn ' t go into every room and sometimes didn ' t look behind the doors. She stated the dirt on the floors was under the wax and needed to be stripped. She stated there wasn ' t a schedule to strip and wax the floors, but they had an employee that was responsible for it. She stated she would like them to see them cleaned better and they are working on getting them done.<br><br>On 7/25/19 at 3:54 PM, an interview was conducted with the Director of Nursing. She stated she would expect the boot Resident #106 used to be clean when it was in use.<br><br>On 7/25/19 at 4:00 PM, an interview was conducted with the Administrator. She stated she expected the floors and the windows to be clean. She stated they are looking into getting a person for the floors so a better job can be done cleaning them. She stated she usually has the windows cleaned yearly and it was about a year ago they were last cleaned and it ' s now time again to have them cleaned. | F 584 | residents with pressure reducing boots to ensure that they are cleaned. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurs | |
| F 624 | Preparation for Safe/Orderly Transfer/Dschrg | F 624 | | 8/22/19 |

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| F 624 SS=D | Continued From page 19 CFR(s): 483.15(c)(7) | F 624 | | |

§483.15(c)(7) Orientation for transfer or discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and outside agency interviews, the facility failed to provide a safe discharge for a resident who required the use of a rolling walker for safe ambulation, the facility did not make provisions for the resident to have a rolling walker when he was discharged from the facility for 1 of 2 residents (Resident 361) reviewed for a discharge home.

The findings included:

Resident #361 was admitted to the facility on 3/28/19 with a diagnosis of pneumonia.

A review of the 5-day Minimum Data Set assessment dated 4/4/19 revealed Resident #361 was cognitively intact. He required extensive assistance with bed mobility, and minimal assistance with ambulation.

A physical therapy discharge summary dated 4/5/19 revealed Resident #361 ' s current level of functioning was ambulation with a rolling walker and supervision. The discharge plan was for Resident #361 to discharge home with family with recommendations for home health and a rolling walker.

The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F624 Preparation for Safe/Orderly Transfer/Discharge
Corrective Action:
Resident #361: Discharged on 4/7/2019.
Identification of other residents who may be involved with this practice:
All residents being discharged home with durable medical equipment ordered have the potential to be affected by this practice. On 8/15/2019 to 8/19/2019 a review of all discharges to home with home health for the last 30 days were reviewed to ensure that residents durable medical equipment is provided per

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| F 624 | Continued From page 20<br><br>A nurse ' s note dated 4/7/19 at 2:33 PM revealed Resident #361 required minimal assistance with activities of daily living and transfers.<br><br>A discharge summary dated 4/7/19 revealed Resident #361 needed a rolling walker which was ordered and would be receiving physical therapy after discharge. The discharge summary indicated the referral was made by the facility staff to the agency.<br><br>An interview was conducted on 7/24/19 at 1:47 PM with Physical Therapist #1. She stated Resident #361 discharge from their caseload using a rolling walker. Resident #361 did have a cane, but a rolling walker was recommended on discharge.<br><br>A physician ' s order for Resident #361 specified he was to be discharged home on 4/7/19 with a rolling walker.<br>A discharge summary note by the Nurse Practitioner (NP) dated 4/5/19 noted Resident #361 was seen for discharge visit. He stated he was feeling better and ambulated with a rolling walker. The NP indicated Resident #361 would be going home with home health physical therapy to continue his therapy.<br><br>A nurse ' s note dated 4/7/19 at 8:02 PM revealed Resident #361 discharged home with family. Discharge summary and medication schedule were reviewed. Verbal and written education was provided. Escorted into family members car safely. There was no mention of Resident #361 having a rolling walker.<br><br>A Start of Care Physical Therapy Clinical Note | F 624 | physician orders. All discharged residents reviewed to have been provided with durable medical equipment per physician orders. This was completed on 8/19/2019.<br>Systemic Changes:<br>All Full Time and Part Time and PRN, social services department staff will be educated on the following by the Administrator; orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Durable Medical equipment must be provided as ordered by physician for residents being discharge home.<br>Education began on 8/16/19.<br>This in service was completed by 8/19/2019. Any social services department staff (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Administrator and or Director of Nursing will review 5 residents discharged home to ensure that durable medical equipment is provided per physician orders. This will be done on | |

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| F 624 | Continued From page 21<br>dated 4/12/19 by the home health physical therapist revealed Resident #361 ' s ambulation was unsteady and unsafe and he required use of a rolling walker. The note indicated Resident #361 had ambulated 50 feet x 2 with the use of a cane, not a rolling walker, as recommended.<br><br>An interview was conducted on 7/24/19 at 1:35 PM with the facility ' s social worker. He stated, on admission, there was a discussion about what will take place after a resident completes therapy and what equipment will be needed at home. He stated he received weekly updates from the therapy department about Resident #361 ' s progress, recommendations for his needs, requested a physician ' s order, made sure it was signed and staffed it with a home health agency. He stated Resident #361 had an order to discharge home with a rolling walker. He stated he chose a home healthcare agency for Resident #361 and the information was faxed to them and he followed up with a phone call to determine the start of care date and whether equipment needed to be picked up or would be delivered. He did not have a copy of the information that he faxed to the home healthcare agency or information on how Resident #361 would receive the rolling walker.<br><br>An interview was conducted on 7/25/19 at 8:02 AM with a representative from the home health care agency the facility ' s social worker set up for Resident #361. She stated the home care agency did not provide durable medical equipment (walker), patients would need to get that from a durable medical equipment provider. She didn ' t know whether the family of Resident #361 knew that information or not. She was able to get in touch with the physical therapist that | F 624 | weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |

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| F 624 | Continued From page 22<br>began home care therapy with Resident #361 who confirmed Resident #361 did not have a rolling walker at the start of care but got it soon after.<br><br>A follow up interview with the social worker conducted on 7/25/19 at approximately 8:15 AM revealed he was unaware that the home care agency selected for Resident #361 did not provide durable medical equipment to the residents and one was not provided to Resident #361 prior to discharge home. | F 624 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect a significant weight loss for 1 of 8 residents (Resident #47) reviewed for Nutrition and to indicate the fall history for 1 of 3 residents (Resident # 98) reviewed for Accidents.<br><br>The findings included:<br><br>1. Resident #47 was admitted to the facility on 12/14/17 with re-entry from a hospital on 5/24/19. Her cumulative diagnoses included non-Alzheimer ' s dementia, a Stage IV pressure ulcer on the sacrum (a triangular-shaped bone at the bottom of the spine), and placement of a gastrostomy tube (a tube placed into the stomach for nutritional support). | F 641 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F641 Accuracy of Assessments<br>Corrective Action:<br>Resident #47: Resident Minimum Data Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) | 8/22/19 |

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| F 641 | Continued From page 23<br><br>A review of Resident #47 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/31/19 indicated the resident had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Livings (ADLs). Section K of the MDS reported the resident ' s weight at the time of the assessment was 111 pounds (#). The assessment indicated the resident did not have a significant weight loss of 5 percent (%) or more in the last month or a loss of 10% or more in the last 6 months. This portion of the 5/31/19 MDS was signed as having been completed by MDS Nurse #1.<br><br>An interview was conducted on 7/24/19 at 10:23 AM with the facility ' s consultant Registered Dietitian (RD). Upon request, the RD reviewed Section K of Resident #47 ' s MDS assessment dated 5/31/19. The RD confirmed Section K did not report the resident had a significant weight loss. The RD then calculated Resident #47 ' s weight loss from her weight on 11/14/18 (124.0#) to the resident ' s weight on 5/24/19 (111.4#) used at the time of the MDS assessment. The RD reported the weight loss would have been 10.1%. Upon further inquiry, the RD stated she would have coded the 5/31/19 MDS to indicate Resident #47 had a significant weight loss of more than 10% in the last 180 days.<br><br>An interview was conducted on 7/24/19 at 1:59 PM with MDS Nurse #1. During the interview, the MDS nurse reviewed Section K of Resident #47 ' s MDS assessment dated 5/31/19. After reviewing the resident ' s weight history, the MDS nurse reported this MDS should have been coded to reflect Resident #47 had a significant weight | F 641 | [5/31/2019] was modified with a Corrective Attestation Date of 7/26/2019. The assessment was submitted to the state QIES system on 7/26/2019 and was accepted on 7/30/2019. Submission ID: 17186422<br>Resident #98: Resident Minimum Data Set (MDS) assessment (Quarterly) with Assessment Reference Date (ARD) [6/30/2019] was modified with a Corrective Attestation Date of 7/25/2019. The assessment was submitted to the state QIES system on 7/26/2019 and was accepted on 7/26/2019. Submission ID: 17173291<br>Identification of other residents who may be involved with this practice:<br>All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by the MDS Nurse Consultant to review the most recent Minimum Data Set (MDS) in the last 6 months to ensure that all residents with a weight loss of 5% or more in the last month or loss of 10% of more in the last 6 months from their ARD were coded accurately in section K0300 (Weight loss) and to ensure that Section J1800 [ Number of falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)] was coded accurately. Of the 95 current residents, 3 assessments were modified for Section K0300 for weight loss and all residents were coded accurately for their quarterly assessments for Section J1800 for falls. This was completed on | |

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| F 641 | Continued From page 24<br>loss within the last 180 days.<br><br>An interview was conducted with the facility ' s Director of Nursing (DON) on 7/24/19 at 4:16 PM. During the interview, the DON reported she would expect the residents ' MDS assessments to be coded accurately.<br><br>2. Resident #98 was admitted to the facility on 11/14/17 with diagnoses which included: epilepsy, Parkinson's disease, and osteoporosis.<br><br>Review of the incident report and nurse's note dated 5/7/19 revealed during an assisted transfer to a chair Resident #98 became weak and was lowered to the floor by the nursing assistant.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 6/30/19 indicated Resident #98 was moderately cognitively impaired; was totally dependent for transfers; and had no falls since the prior assessment. Section J1800 of the MDS dated 6/30/19 did not reflect Resident #98's fall on 5/7/19.<br><br>During an interview on 7/25/19 at 5:02 p.m., MDS Nurse#1 revealed she was not aware Resident #98 had a fall on 5/7/19 and confirmed Resident #98's 6/30/19 MDS was inaccurate regarding having no falls since the prior MDS assessment. | F 641 | 8/19/2019.<br>Systemic Changes:<br>On 8/16/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident's status. Section K0300(Weight loss). Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1. Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS. • If the resident is | |

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| F 641 | Continued From page 25 | F 641 | losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status. • To code K0300 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented. • On occasion, a resident with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is not to induce weight loss, and it would not be considered a physician-ordered weight-loss regimen. Section J1800 [ Number of falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)]: Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100). • Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent.<br>This in service was completed by 8/19/2019. Any The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information | |

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| F 641 | Continued From page 26 | F 641 | has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section J1800 [ Number of falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)]: and Section K0300(Weight loss) was coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary | |

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| F 641 | Continued From page 27 | F 641 | Manager, Wound Nurse. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to | F 656 | | 8/22/19 |

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| F 656 | Continued From page 28<br>local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, resident and staff interviews, the facility failed to develop person centered care plans in the areas of oxygen therapy and pain management and for risk of or actual pressure ulcer development for 2 of 28 sampled residents (Residents #92 & #106).<br><br>Findings included:<br><br>1a. Resident #92 was admitted to the facility on 1/16/18 with diagnoses which included: pneumonia, chronic obstructive pulmonary disease and congestive heart failure.<br><br>Review of the quarterly minimum data set (MDS) dated 5/10/19 indicated Resident #92 was cognitively intact and received oxygen therapy.<br><br>Review of Resident #92's most recent care plan revealed oxygen therapy was not addressed.<br><br>During an observation and interview on 7/21/19 at 4:05 p.m., an oxygen concentrator was observed next to Resident #92's bed. The resident revealed he received oxygen therapy at night, when needed.<br><br>During an interview on 7/25/19 at 4:52 p.m., MDS Nurse#1 revealed Resident #92 received scheduled oxygen therapy at night when needed | F 656 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F656 Develop/Implement Comprehensive Care Plan<br>Corrective Action:<br>Resident #92 and 106: Care plans reviewed and updated on 7/30/2019.<br>Identification of other residents who may be involved with this practice:<br>All current residents with oxygen therapy, on pain management and at risk of or actual pressure ulcer development have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by the Minimum Data Set (MDS) Nurse Consultant and Minimum Data Set Coordinators, to ensure that a care plan was implemented for current residents with oxygen therapy, on pain management and at risk of or | |

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| F 656 | Continued From page 29<br>and this should have been care planned.<br><br>1b. Resident #92 was admitted to the facility on 1/16/18 with diagnoses which included: peripheral vascular disease, gout, and a history of malignant neoplasm of the large intestine.<br><br>Review of the quarterly minimum data set (MDS) dated 5/10/19 indicated Resident #92 was cognitively intact; had frequent pain; and received scheduled and when needed pain medication.<br><br>Review of Resident #92's most recent care plan revealed pain management was not addressed.<br><br>During an observation and interview on 7/21/19 at 4:00 p.m., Resident #92 requested and received pain medication (oxycodone 5) for pain in his left foot. When the nurse asked on a scale of 0 to 10 (10 being intense pain), the resident indicated his pain was at a pain scale level of 10.<br><br>During an interview on 7/23/19 at 1:25 p.m., the facility's Medical Director revealed Resident #92 received pain medications due to his complaints of intermittent gout. He stated that the resident received prn (when necessary) .6mg (milligram) hydrocodone and prn .6mg oxycodone to be given independently every six hours.<br><br>During an interview on 7/25/19 at 4:45 p.m., MDS Nurse#1 stated that at the time of Resident #92's comprehensive assessment, the resident's pain was controlled; he was not asking/receiving prn pain medication, so there was no CAA (care area assessment) to trigger a care plan for pain.<br>2. Resident #106 was admitted to the facility on 7/27/18 with a diagnosis of right heel pressure ulcer. | F 656 | actual pressure ulcer development. All current residents with pressure ulcers have updated care plans. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident's exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident's representative's on the residents goals for admission and desired outcomes, the resident's preference and potential for future discharge, and discharge plans. A comprehensive person | |

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| F 656 | Continued From page 30<br><br>A review of an annual Minimum Data Set (MDS) assessment dated 7/3/19 revealed Resident #106 had the presence of a pressure ulcer and was at risk for pressure ulcers. The care area assessment indicated the area of pressure ulcers was triggered and would be addressed in the care plan.<br><br>A review of the care plan dated 7/3/19 revealed no problem for risk of or actual pressure ulcer.<br><br>An observation of wound care was completed on 7/22/19 at 10:39 AM. Resident #106 was observed to have a healing deep tissue injury to her right heel approximately nickel sized and observed with a greenish/brown covering. The area was cleaned with wound cleanser and skin prep was applied.<br><br>An interview with NA #1 on 7/22/19 at 8:41 AM revealed she knew what Resident #106 needed by the Kardex and shift report from the nursing assistant and the nurse.<br><br>An interview with MDS nurse #1 on 7/25/19 revealed she was surprised Resident's #106 current and risk of pressure ulcers was not care planned and she thought it had been. | F 656 | centered care plan must be implemented for all residents requiring catheter care and must be developed for all resident's receiving activities of daily living that identifies the type of care needed for activities of daily living.<br>This in service was completed by 8/22/2019. Any Minimum Data Set nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident's requiring oxygen therapy, on pain management and at risk of or actual pressure ulcer development to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months.The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and | |

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| F 656 | Continued From page 31 | F 656 | ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. | F 657 | | 8/22/19 |

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| F 657 | Continued From page 32<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to revise the care plan of 1 of 7 sampled residents (Resident #161) who developed a stage two pressure ulcer to her right hip.<br><br>Findings included:<br><br>Resident #161 was admitted to the facility on 5/1/11 with diagnoses which included: dementia with behavioral disturbance and diabetes mellitus.<br><br>Review of the care plan dated 6/3/18 revealed Resident #161 was at risk for impaired skin integrity related to limited bed mobility and urinary and bowel incontinence secondary to hemiplegia, dementia and diabetes mellitus. Interventions included: observe skin for redness/open areas and inform nurse if any areas noted; and weekly full body skin assessments.<br><br>The Weekly Pressure Ulcer Review dated 7/19/18 revealed Resident #161 was noted with a stage 2 pressure ulcer to her right hip on 7/18/18.<br><br>Review of the quarterly minimum data set (MDS) dated 7/26/18 indicated Resident #161 was severely, cognitively impaired and had developed a stage two pressure ulcer.<br><br>Resident #161's care plan was not revised to include the stage two pressure ulcer on her right hip.<br><br>Review of the Weekly Pressure Ulcer Review dated 8/1/18 revealed the stage 2 pressure ulcer on Resident #161's right trochanter (hip) had | F 657 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F657 Care Plan Timing and Revision<br><br>Corrective Action:<br>Resident #161: Care plans reviewed and updated on 7/30/2019.<br>Identification of other residents who may be involved with this practice:<br>All current residents with pressure ulcers have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by the Minimum Data Set (MDS) Nurse Consultant and Minimum Data Set Coordinators, to ensure that a care plan was implemented for current residents with pressure ulcers. All current residents with pressure ulcers have updated care plans. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/16/2019 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced | |

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| F 657 | Continued From page 33<br>healed and was resolved by the physician.<br><br>During an interview on 7/23/19 at 3:46 p.m., the Treatment Nurse revealed he was not the treatment nurse during Resident #161's stay at the facility. However, after reviewing the resident's wound records, he stated that the resident had a stage two to her right hip with the onset date of 7/18/18 and was resolved on 8/1/18 by the physician.<br><br>During an interview on 7/25/19 at 5:23 p.m., MDS Nurse#1 acknowledged Resident #161's care plan was not revised in July 2018 but should have been to include the stage two pressure ulcer to the resident's right hip. | F 657 | /educated by the Minimum Data Set Nurse consultant.<br>The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident□s highest practicable physical, mental, and psychosocial wellbeing; and any services that would otherwise be required but are not provided due to the resident□s exercise of rights , including the right to refuse treatment ; and any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations, and after consultation with the resident and the resident□s representative□s on the residents goals for admission and desired outcomes, the resident□s preference and potential for future discharge, and discharge plans. A comprehensive person centered care plan must be implemented for all residents requiring catheter care and must be developed for all resident□s receiving activities of daily living that identifies the type of care needed for activities of daily living.<br>This in service was completed by 8/19/2019. Any Minimum Data Set nurse | |

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| F 657 | Continued From page 34 | F 657 | (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident□s with pressure ulcers to ensure that care plan is implemented. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 677 | ADL Care Provided for Dependent Residents | F 677 | | 8/22/19 |

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| F 677 SS=D | Continued From page 35<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, Nurse Practitioner (NP) and staff interviews, and record reviews, the facility failed to provide staff assistance with eating for a resident identified to have an unplanned weight loss related to poor oral intake and with written physician orders to be fed all meals. This occurred for 1 of 7 residents (Resident #81) reviewed for Activities of Daily Living.<br><br>The findings included:<br><br>Resident #81 was admitted to the facility on 6/13/17 from another nursing facility. The resident ' s cumulative diagnoses included non-Alzheimer ' s dementia and dysphagia (difficulty swallowing).<br><br>A review of the resident ' s medical record revealed her weight on 1/24/19 was reported to be 84.4 pounds (#).<br><br>A review of Resident #81 ' s most recent quarterly Minimum Data Set (MDS) dated 6/11/19 revealed the resident had moderately impaired cognitive skills for daily decision making. The MDS assessment indicated Resident #81 required extensive assistance from staff for bed mobility, transfers, eating, and toileting; she was totally dependent on staff for locomotion on and off the unit, dressing and personal hygiene. Section K of the MDS reported the resident weighed 79 | F 677 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F677 ADL Care Provided for Dependent Residents<br>Corrective Action:<br>Resident #81: Resident assisted with eating all meals per physician orders.<br>Identification of other residents who may be involved with this practice:<br>All current residents with physician orders to be assisted with all meals have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by the Minimum Data Set (MDS) Nurse Consultant and MDS Coordinators, to ensure that a care plan was implemented for current residents with physician orders to be fed all meals. All current residents with physician orders to be assisted with all | |

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| F 677 | Continued From page 36 | F 677 | | |

pounds (#) and received a therapeutic and mechanically altered diet.

A review of Resident #81 ' s current care plan was completed. The care plan included an area of focus (not dated) related to a potential nutritional problem due to fair meal intake, and receiving a mechanically altered and therapeutic diet. The planned goal for this area of focus was for the resident to maintain adequate nutritional status as evidenced by maintaining weight with no significant changes and eating 50% or more of her meals. The care plan also included an area of focus (not dated) related to an unplanned weight loss due to poor food intake. The planned goal was for the resident to consume 50% to 75% at two of three meals daily through the next 90 days.

Review of the resident ' s diet order revealed she was prescribed a low potassium, National Dysphagia Diet (NDD) Level 3 diet with liquids of thin consistency. An NDD Level 3 diet is one which includes moist foods in bite-size pieces making it easier to chew and swallow. A Mighty Shake (high calorie, high protein nutritional supplement) was also ordered (initiated on 4/11/18) to be provided with meals for extra calories.

A review of Resident #81 ' s medical record revealed the resident was seen on 7/1/19 for a monthly visit by Nurse Practitioner (NP) #1. NP #1 noted the resident had an ongoing progressive decline in overall functional and mental status related to dementia and debility. The resident ' s was reported to refuse care at times and having variable cognition. It was also reported Resident #81 alternated between feeding self and needing assistance with meals. NP #1 indicated an order

meals have those orders implemented. This was completed on 8/19/2019.
Systemic Changes:
On 8/19/2019 the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) that a resident who is unable to carryout activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; The facility must ensure to provide assistance with eating for all resident with physician orders to be fed all meals.
This in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed.
This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.
Monitoring:
To ensure compliance, The Director of Nursing or Unit Manager will observe 5 residents each week to include the weekend who have physician orders to be fed all meals to ensure that orders are implemented at breakfast, lunch and dinner. This will be done on weekly basis for 4 weeks then monthly for 3 months.
The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assuarance Committee by

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| F 677 | Continued From page 37<br>would be written for the resident to be assisted with all meals.<br><br>On 7/2/19, an order was written by NP #1 which provided instruction for Resident #81 to be fed all meals. This order was noted to have been typed in all capital letters in Resident #81 ' s electronic medical record.<br><br>Further review of Resident #81 ' s electronic medical record included a Nursing Note dated 7/6/19 at 1:38 PM. This note was a Medication Administration Note which read (in capital letters), "Resident to be fed all meals with meals." The note also reported the Nursing Assistant (NA) was notified.<br><br>A review of the resident ' s medical record revealed her weight on 7/16/19 was reported to be 80.0#.<br><br>A review of Resident #81 ' s electronic Kardex Report (printed on 7/22/19) revealed the following instructions on Eating/Nutrition were listed as follows:<br>--Give me supplements as ordered. Alert nurse/dietary manager if not consuming on a routine basis;<br>--I need staff assistance with meal and snack intake (noted on 11/3/17);<br>--Monitor and record food intake at each meal;<br>--Offer substitutes as requested or indicated. I prefer: (left blank);<br>--Please assist me into my wheelchair prior to meals;<br>--Provide and serve supplements as ordered; and,<br>--Provide, serve diet as ordered. Monitor intake and record every meal. | F 677 | the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |

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| F 677 | Continued From page 38 | F 677 | | |

An observation was made of Resident #81 sitting up in bed with a breakfast tray placed on her bedside table on 7/22/19 at 8:29 AM. No staff member was in the room at the time of the observation. A continuous observation was made as the resident was observed to use her fingers to feed herself some of the scrambled eggs and bread. On 7/22/19 at 8:45 AM, the resident was noted to have eaten approximately ¼ of the scrambled eggs and ½ slice of bread. An attempt was made at that time to interview the resident; she was not interviewable. The resident attempted to say something (not understandable) as she appeared to point to a cup of light brown liquid (identified as tea by the resident ' s meal ticket). On 7/22/19 at 8:49 AM, the resident was observed from the hallway as she reached for her tea. No staff member was observed to enter the room. On 7/22/19 at 9:02 AM, the resident was observed to have stopped feeding herself breakfast. At that time, approximately 2 ounces of tea had been consumed in addition to the ¼ scrambled eggs and ½ slice of bread previously noted. No staff member was observed to enter the room to assist the resident with her meal during the continuous observation. On 7/22/19 at 9:16 AM, the resident appeared to be asleep. On 7/22/19 at 9:18 AM, Nursing Assistant (NA) #6 was observed as she went into the resident ' s room and removed the breakfast tray.

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A second continuous observation was made beginning at 1:00 PM on 7/22/19 when NA #6 was observed to bring Resident #81's lunch meal tray into the resident ' s room. The NA provided meal set-up for the resident and left the room at 1:03 PM. On 7/22/19 at 1:49 PM, the resident was still in her room alone with her lunch tray in

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|---|---|---|---|---|
| F 677 | Continued From page 39 | F 677 | | |

front of her. The resident was observed to have consumed approximately 10% of her meat and mashed potatoes and ¼ slice of bread; no soup, vegetables, or cake had been eaten; and, no ice cream had been consumed (the ice cream container was noted as not having been opened). No staff member was observed to have entered the resident ' s room to assist her with the meal during this period of time.

On 7/22/19 at 1:50 PM, NA #6 entered Resident #81 ' s room and was overheard from the hallway as she asked the resident, "Are you finished eating?" No response from the resident could be heard. NA #6 picked up the resident ' s lunch tray and was observed as she exited the room with it.

An interview was conducted on 7/22/19 at 1:50 PM with NA #6. When asked whether the resident was able to feed herself, the NA stated she was. Upon further inquiry, the NA stated Resident #81 typically did pretty well with eating and usually ate 50% of her meals.

A follow-up interview was conducted on 7/22/19 at 2:22 PM with NA #6. During the interview, the NA reported she was "released (from training) on Sunday" and was no longer working with another NA for orientation. When asked how she would know what care each resident required, NA #6 stated she could look on the computer (referring to the electronic Kardex Report).

An interview was conducted on 7/23/19 at 2:45 PM with NA #7. NA #7 reported she was the 1st shift NA who was frequently assigned to care for Resident #81. When asked about Resident #81 ' s meal intake, the NA stated the resident did not eat much. She reported Resident #81 would try

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| F 677 | Continued From page 40<br>to eat finger foods and drink her tea, but that was likely about all. Upon inquiry, the NA stated the resident needed to be fed by staff.<br><br>A telephone interview was conducted on 7/24/19 at 12:00 PM with NP #1. During the interview, the continuous observations made of Resident #81 trying to feed herself two consecutive meals without staff assistance was discussed. NP #1 stated, "I think that is unfortunate because (Resident #81) could help herself at one time with finger foods." The NP reported the resident was not doing very well anymore even with finger foods and that she could not use utensils. NP #1 stated that Resident #81 needed to be fed all meals.<br><br>An interview was conducted on 7/24/19 at 4:16 PM with the facility ' s Director of Nursing. During the interview, the provider ' s order for Resident #81 to be fed all meals was discussed, along with the continuous observations of the resident attempting to feed herself two meals without assistance on 7/22/19. The DON questioned how the order was entered into the electronic medical record and whether the entire system of communication had been followed so nurses and nursing assistants knew of the need to feed this resident. The DON indicated she would need to investigate this further. However, the DON stated if an order had been received to feed a resident all meals, she would expect staff to feed the resident the meals. | F 677 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers. | F 686 | | 8/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345284 | A. BUILDING _____ B. WING _____ | C 07/25/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 686 | Continued From page 41<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to implement pressure reducing devices for a resident with a pressure ulcer for 1 of 7 (Resident #106) residents reviewed for pressure ulcers.<br><br>The findings included:<br><br>Resident #106 was admitted to the facility on 7/27/18 with diagnosis of right heel pressure ulcer.<br><br>A review of the annual Minimum Data Set assessment dated 7/3/19 revealed Resident #106 needed extensive assistance x 2 people for bed mobility and transfers, was non-ambulatory and had a deep tissue injury present on admission and was at risk for pressure ulcer development.<br><br>A July 2019 physician's orders revealed an order for a pressure relieving boot to the right heel at all times, dated 7/13/19.<br><br>An observation made on 7/22/19 at 8:41 AM revealed Resident #106 had a pressure relieving | F 686 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>Corrective Action:<br>Resident #106: Pressure reducing device implemented for resident per physician orders.<br>Identification of other residents who may be involved with this practice:<br>All current residents with pressure ulcers have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by the | |

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| F 686 | Continued From page 42<br>boot to the left (unaffected) foot.<br><br>An observation was conducted on 07/22/19 at 10:39 AM of wound care to Resident #106 ' s right heel wound by the treatment aid. The procedure was explained to the resident. The resident was assessed for pain. The right heel was observed with an area approximately nickel sized to right heel, covered over with green/brown dried skin. The area was cleaned with wound cleanser and skin prep was applied.<br><br>An interview on 7/22/19 at 8:41 AM with NA #1 revealed the boot should have been on the right foot and she didn't know why it was on the wrong foot.<br><br>An observation made on 7/24/19 a 10:10 AM revealed Resident #106 lying in her bed with her feet against the footboard. No boot was observed to her right foot or in the bed.<br><br>An interview on 7/24/19 at 10:15 AM with NA #1 revealed she didn't know why Resident #106 did not have her boot on the right foot.<br><br>An interview on 7/25/19 at 3:54 PM with the Director of Nursing revealed if there is an order for pressure relieving devices to be used at all times, they should be in place at all times. | F 686 | Director of Nursing, Unit Managers and Minimum Data Set Coordinators to ensure that pressure reducing devices were implemented for residents with pressure ulcers per physician orders. All pressure reducing devices ordered by physician are implemented. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019 the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses and Nurse Aides: Full time, Part time and PRN) that a Skin Integrity (b)(1) Skin Integrity 1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Pressure reducing devices must be implemented per orders.<br>This in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the | |

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|---|---|---|---|
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| F 686 | Continued From page 43 | F 686 | Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing or Unit Manager will observe 5 residents each week to include the weekend with physician orders to have pressure reducing devices, to ensure that they are implemented as ordered. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate | F 689 | | 8/22/19 |

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| F 689 | Continued From page 44<br>supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to keep the environment free of safety hazards by placing positioning wedges on both sides of the bed putting the resident at higher risk of injury by the resident going over the wedges and falling for 1 of 3 residents (Resident #47) reviewed for accidents.<br><br>The findings included:<br><br>Resident #47 was admitted to the facility on 12/14/17 with re-entry from a hospital on 5/24/19. Her cumulative diagnoses included non-Alzheimer ' s dementia and a Stage IV pressure ulcer on the sacrum (a triangular-shaped bone at the bottom of the spine).<br><br>A review of a Fall/Incident Report dated 3/13/19 at 6:41 AM described an unwitnessed incident when Resident #47 was observed on the floor screaming for help. She was reported to be unable to state what transpired. No injuries were noted.<br><br>Review of a Fall/Incident Report dated 3/16/19 at 2:15 PM was completed. The incident description noted a nursing assistant (NA) heard the resident calling for help when she was walking down the hall. The resident was found on the floor beside her bed. The resident was reported to have sustained a small abrasion on her left knee and bruise on her right knee. | F 689 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F689 Free of Accident Hazards/Supervision Devices<br>Corrective Action:<br>Resident #47: Positioning wedge removed on 7/25/19.<br>Identification of other residents who may be involved with this practice:<br>All current residents with positioning wedges on both sides of the bed have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by Director of Nursing to ensure that positioning wedges on both sides of the bed were not utilized for residents who were at risk for falls. No resident has two positioning wedges in place. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019 the Director of Nursing and Unit Manager began in-servicing the nursing staff (Registered nurses and Nurse Aides: Full time, Part time and | |

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| F 689 | Continued From page 45<br>A review of Resident #47 ' s Minimum Data Set (MDS) included a significant change assessment dated 3/19/19. The MDS revealed the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Livings (ADLs). Section G of the MDS coded the resident as requiring extensive assistance for bed mobility and transfers. A review of the Care Area Assessments for this MDS included the following care plan considerations on the topic of Falls: "At risk for falls due to being dependent on staff for all transfers and mobility. She is also diagnosed with memory deficits and is not capable of making appropriate decisions for herself as evidenced by a history of multiple falls because she believes she can walk. A fall could result in fractures, increased pain and readmission to the hospital. Staff intervention is necessary for identification and reduction of risk factors.<br><br>A review of a Fall/Incident Report dated 4/11/19 at 6:25 PM described an unwitnessed incident when Resident #47 called out for help and was found on the floor beside the bed lying face down on her right side. No injuries were reported.<br><br>A review of Resident #47 ' s Device and Bed Rail Review dated 4/17/19 was conducted. Question #2 on the form inquired if any devices were used. The answer was "None."<br><br>Review of a Fall/Incident Report dated 5/4/19 at 4:30 PM revealed an NA observed the resident lying on the floor beside her bed. No injuries were reported.<br><br>A review of a Fall/Incident Report dated 5/19/19 | F 689 | PRN) Accidents. The facility must ensure that (d)(1) The resident environment remains as free of accident hazards as is possible; and (2)Each resident receives adequate supervision and assistance devices to prevent accidents. Positioning devices such as wedges are used per physician orders to aid in wound healing so as to offload pressure on the pressure ulcer/injury and to assist with turning and repositioning. Positioning devices /wedges are not to be utilized on both sides for resident who are at risk for falls.<br>This in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing or Unit Manager will observe 5 residents at risk for falls and who use positioning devices , each week to include the weekend , to ensure that they don□t have two positioning wedges on both sides of the bed. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) | |

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| F 689 | Continued From page 46<br>at 9:55 PM described an incident when Resident #47 had an unobserved fall and was found lying on the floor next to her bed. The resident sustained a laceration to the left side of her forehead and was transported to the Emergency Room (ER) for evaluation and treatment. She returned from the hospital on 5/24/19 at 12:30 PM with a diagnoses which included a hematoma to the left temporal area of the head.<br><br>A review of Resident #47 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/31/19 indicated the resident had moderately impaired cognitive skills for daily decision making. The resident continued to require extensive assistance from staff for all of her Activities of Daily Livings (ADLs).<br><br>A review of the current care plan (not dated) for Resident #47 included a focus area related to her risk for development of pressure ulcers and healing of a Stage IV pressure ulcer to her coccyx (tail bone)/sacral area. The interventions included, in part, use of a pressure reducing mattress on her bed and staff assistance with frequent position changes/turning for pressure reduction and comfort. The use of positioning wedges was not included as an intervention for this area of focus. The current care plan also included a focus area related to falls, which indicated the resident continued to be at risk for falls with injuries related to confusion. The care plan interventions did not include the use of positioning wedge(s) while the resident was in bed.<br><br>A review of the resident ' s electronic Kardex Report (printed on 7/22/19) was conducted. The Kardex Report did not indicate positioning | F 689 | Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |

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|---|---|---|---|
| | 345284 | A. BUILDING _____ B. WING _____ | C 07/25/2019 |

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| F 689 | Continued From page 47 | F 689 | | |

wedge(s) were used while the resident was in bed.

An observation was conducted on 7/25/19 at 4:50 PM of the resident lying asleep in bed with bed covers pulled over her. At that time, there appeared to be an elevated perimeter on both sides of the bed. The resident was not interviewable.

An interview was conducted on 7/25/19 at 4:53 PM with Nurse #2. Nurse #2 was the 2nd shift hall nurse assigned to care for Resident #47. Upon inquiry, the nurse stated she believed bumpers had been used for the resident over the past 2 weeks or so. When asked why they were being used, the nurse stated it was to help keep her in bed because the resident had a history of recent falls. When Nurse #2 was asked who may have initiated the bumpers placed on Resident #47 ' s bed, she suggested the facility ' s Treatment Nurse might be able to provide more insight into this.

An interview was conducted on 7/25/19 at 5:00 PM with the facility ' s Treatment Nurse and inquiry was made into the use of bumpers on the bed for Resident #47. The nurse was observed as he went to the resident's room and pulled down the bed covers, exposing 2 positioning wedges on the bed (with one wedge placed on each side of the resident). The Treatment Nurse reported the wedges should not be used in the manner they were placed. He stated while one wedge could be used to position the resident, the second one should not be there. The nurse was observed as he removed one wedge from the bed. He then instructed Nurse #2 and NA #4 that the wedges could not be used in this way while

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 689 | Continued From page 48 | F 689 | | |

Resident #47 was in bed. The Treatment Nurse reported he would be calling in to the facility during 3rd shift that evening and would talk with the nursing staff to ensure positioning wedges were no longer used in the manner they had been observed.

An interview was conducted on 7/25/19 at 5:05 PM with NA #4. NA #4 was the 2nd shift nursing assistant assigned to care for Resident #47. When asked, the NA stated the purpose of the wedges being placed on each side of the bed was, "To keep her from falling out of bed." During the interview, the NA reported she thought positioning wedges had been used in this manner for about two months and she inquired as to what other measures they (staff) could take to keep the resident from falling out of the bed.

A follow-up interview was conducted on 7/25/19 at 5:26 PM with the Treatment Nurse. During the interview, the nurse explained the positioning wedges found on Resident #47 ' s bed should not have been positioned under the bed sheet as they were found to be. Instead, one wedge should be positioned between the turn sheet and the bed sheet, and that wedge would stay in place until the resident was re-positioned. He stated, "I am part of the team that does the interventions for the falls." The nurse described the procedure used to put interventions into place for a resident who had fallen. He reported the day after a resident fell, nursing staff would conduct an interdisciplinary team (IDT) meeting. The IDT would attempt to determine the intrinsic and extrinsic risk factors related to the resident ' s fall. These factors may include the resident ' s history of previous falls, diagnoses, cognition, pain meds, labs and psychotropic medications (all

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 689 | Continued From page 49 | F 689 | | |

risk factors), in addition to any known root causes. He reported the IDT would look at all the factors and try to come up with an appropriate intervention. The Treatment Nurse stated he assumed responsibility for taking the minutes of the IDT meeting and for adding the interventions to the resident ' s incident report. The MDS nurse who attended the morning meeting would be responsible to care plan the interventions implemented. The Treatment Nurse stated that if a resident had fallen, he would not recommend the use of positioning wedges as they had been placed for Resident #47. He reported, "It raises the level where the resident would fall from" and stated, "We need to do more education."

An interview was conducted on 7/25/19 at 5:50 PM with the facility ' s Director of Nursing (DON). During the interview, the observation of positioning wedges placed on each side of Resident #47 was discussed. The DON stated she was puzzled as to why two wedges were in place. She stated that normally only one positioning wedge would be used on one side of a resident (not one on each side) and reported the positioning wedges were not intended to be used to try to keep a resident in bed. The DON stated she did not believe having one positioning wedge placed on each side of Resident #47 would have prevented this resident from getting out of bed if she actually wanted to do so. However, the DON also reported two positioning wedges were not intended to be used as they were observed and the wedges should not have been used in that way. When asked, the DON acknowledged the use of a positioning wedge on each side of the resident while in bed could potentially pose a safety risk.

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE OAKS | 901 BETHESDA ROAD WINSTON SALEM, NC 27103 |

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| F 690 | Continued From page 50 | F 690 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by: | F 690 | | 8/22/19 |

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| F 690 | Continued From page 51<br>Based on observations, staff interviews and record review, the facility failed to keep a urinary catheter bag from touching or dragging on the floor to reduce the risk of infection or injury for 2 of 3 residents (Resident #47 and Resident #50) reviewed with indwelling urinary catheters.<br><br>The findings included:<br><br>1) Resident #47 was admitted to the facility on 12/14/17 with re-entry from a hospital on 5/24/19. Her cumulative diagnoses included non-Alzheimer ' s dementia and chronic osteomyelitis of a Stage IV pressure ulcer on the sacrum (a triangular-shaped bone at the bottom of the spine).<br><br>A review of Resident #47 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/31/19 indicated the resident had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of her Activities of Daily Livings (ADLs).<br><br>A review of the current care plan for Resident #47 included a focus area (not dated) related to the use of an indwelling foley catheter for wound healing and risk for bladder infection. The planned goals noted the resident would remain free from catheter-related trauma and show no signs and symptoms of urinary infection through the next review date. Interventions for the goals included the following, in part: the catheter bag and tubing was to be positioned below the level of the bladder; and, tubing should be checked for kinks throughout the shift.<br><br>An initial observation was made on 7/21/19 at | F 690 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F690 Bowel/Bladder Incontinence, Catheter, UTI<br>Corrective Action:<br>Resident #47 and #50: Indwelling urinary catheter not touching or dragging the floor; secured in place.<br>Identification of other residents who may be involved with this practice:<br>All current residents with indwelling urinary catheters have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by Director of Nursing to ensure that all residents with indwelling urinary catheter had securing devices to ensure that the catheters did not touch or drag on the floor. All residents with indwelling urinary catheters have securing devices in place. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019 , the Director of Nursing in serviced all Nursing staff (Registered Nurses, Licensed practical nurse, and Nurse Aides: Full time, Part time and PRN) that the facility must ensure that | |

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| F 690 | Continued From page 52<br>12:50 PM as Resident #47 was lying in bed. A urinary catheter bag was observed to be hanging from the bed frame with approximately 1-inch of the bag lying on the floor.<br><br>An observation made on 7/21/19 at 3:22 PM revealed the resident was asleep in bed. Approximately 6-inches of the catheter bag and 3-inches of the tubing were lying on the floor at the time of the observation.<br><br>An observation was made on 7/22/19 at 9:12 AM as the resident was lying in her bed. A urinary catheter bag was observed to be hanging from the bed frame with approximately 1-inch of the bag lying on the floor.<br><br>Another observation was made on 7/23/19 at 8:30 AM as the resident was lying in her bed. Observation of the urinary catheter bag revealed approximately 2-inches of the catheter bag was lying on the floor.<br><br>Accompanied by the facility ' s Director of Nursing, an observation of Resident #47 was conducted on 7/23/19 at 3:25 PM. Upon observing Resident #47 ' s catheter bag to be lying approximately 1-inch on the floor, the DON stated, "It's touching the floor." During the observation, Nursing Assistant (NA) #4 entered the room. The DON asked NA #4 what was wrong with the catheter bag. The NA replied, "It's too low." The DON stated she would expect that if the catheter bag or tubing touched the floor, it would need to be wiped with a bleach wipe to disinfect it. At the time of this interview, the DON was informed of the previous observations made of Resident #47 ' s catheter bag and/or tubing throughout the past 3 days. The DON stated that | F 690 | resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. For a resident with urinary incontinence based on the residents comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and a resident who is incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel received appropriate treatment and services to restore as much normal bowel function as possible. Also that physician orders have to be obtained for all indwelling catheters and have a medical justification for the use of the catheter. This in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into | |

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|---|---|---|---|---|
| F 690 | Continued From page 53<br>since the catheter bag had been on the floor so frequently, she would prefer to have the bag and tubing changed for the resident. The DON was observed as she requested the hall nurse replace the catheter bag and tubing for Resident #47.<br><br>2) Resident #50 was admitted to the facility on 11/19/15 with re-entry from a hospital on 4/22/19. His cumulative diagnoses included placement of a supra-pubic catheter due to urinary retention.<br><br>A review of Resident #50 ' s significant change Minimum Data Set (MDS) assessment (dated 5/21/19) was completed. The MDS indicated the resident had severely impaired cognitive skills for daily decision making. The resident required extensive assistance from staff for all of his Activities of Daily Livings (ADLs), with the exception of requiring limited assistance for locomotion on the unit and being totally dependent on staff for his personal hygiene. Section H of the MDS assessment indicated the resident had an indwelling urinary catheter.<br><br>A review of the current care plan for Resident #50 included a focus area (not dated) related to the use of a supra-pubic catheter. The planned goals noted the resident would remain free from catheter-related trauma and show no signs and symptoms of urinary infection through the next review date. Interventions for the goals included the following, in part: the catheter bag and tubing was to be positioned below the level of the bladder; and, tubing should be checked for kinks throughout the shift.<br><br>An observation was made on 7/24/19 at 8:45 AM as Resident #50 was sitting in a Broda chair (a tilt-in-space positioning wheelchair) in a common | F 690 | the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing or Unit Manager will observe 5 residents who have indwelling catheter to ensure that the urinary catheter bag is not touching or dragging on the floor to reduce the risk of infection or injury. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |

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| F 690 | Continued From page 54 | F 690 | | |

area of the facility. A urinary catheter bag was observed to be dragging on the floor as the resident slowly self-propelled himself towards the hallway.

An interview was conducted on 7/24/19 at 9:17 AM with Nursing Assistant (NA) #5. NA #5 was in the common area where Resident #50 was observed in his Broda chair. When asked to look at the position of the resident ' s catheter bag, the NA stated, "It ' s too low." The NA was observed as she adjusted Resident 50 ' s chair up so the catheter bag was no longer on the floor. NA #5 was then asked if anything needed to be done with the catheter bag once it was raised off of the floor. The NA reported nothing needed to be done because the catheter tubing had not been on the floor. NA #5 reported if the catheter tubing had been on the floor, it needed to be wiped off with an alcohol wipe.

A telephone interview was conducted on 7/24/19 at 12:00 PM with the facility ' s NP who helped care for Resident #50. During the interview, the observation of the resident ' s catheter bag observed to be dragging on the floor was discussed. The NP stated staff usually did a good job about keeping the catheter bag off of the floor. However, the NP reported she, "would hope it's not on the floor." When asked if there should be an intervention once the catheter bag was taken off of the floor, the NP stated that wiping the bag off with a bleach wipe would have been a good thing to do.

An interview was conducted on 7/24/19 at 4:16 PM with the facility ' s Director of Nursing (DON). During the interview, the observation of Resident #50 ' s catheter bag dragging on the floor was

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| F 690 | Continued From page 55<br>discussed. It was acknowledged at that time the DON had made an observation of another resident ' s catheter bag touching the floor on the previous day (7/23/19). The DON had indicated at that time she expected a catheter bag and tubing to be kept off of the floor. The DON also stated she would expect that if the catheter bag or tubing touched the floor, it would need to be wiped with a bleach wipe to disinfect it. | F 690 | | |
| F 744 SS=D | Treatment/Service for Dementia<br>CFR(s): 483.40(b)(3)<br><br>§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to develop a person centered care plan which addressed the needs of a resident with dementia and how staff were to provide their care and treatment for 1 of 3 residents (Resident #37) reviewed with a diagnosis of dementia.<br><br>Findings included:<br><br>Resident #37 was admitted to the facility on 12/27/17 with multiple diagnoses that included non-Alzheimer's dementia and Parkinson's disease.<br><br>The quarterly Minimum Data Set (MDS) dated 5/9/19 revealed the resident had moderately impaired cognition, needed one to two-person extensive to total assistance for activities of daily | F 744 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F744 Treatment/Service for Dementia<br><br>Corrective Action:<br>Resident #37 : Care plan reviewed and updated.<br>Identification of other residents who may | 8/22/19 |

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| F 744 | Continued From page 56<br>living (ADLs), and had a diagnosis of non-Alzheimer's dementia.<br><br>Review of active Physician Orders and a Physician Note from 5/28/19 revealed that the resident was prescribed Seroquel 12.5 milligrams two times a day.<br><br>Resident #37's care plan dated 6/5/19 revealed there was no care plan developed to address her dementia diagnosis.<br><br>Observations of Resident # 37 on 7/21/19 at 2:35 PM and 7/24/19 at 10:32 AM revealed the resident was confused and yelling out. When the resident was approached, she stated that she did not want to talk because I was having an affair with her husband.<br><br>During an interview with the Nurse #1 on 7/22/19 at 10:30 AM she stated that the resident exhibited behaviors that included yelling out, confusion, poor safety awareness with falls, and delusions about her husband having affairs.<br><br>During and interview with the Medical Director on 7/24/19 at 2:00 PM he stated that Resident #37 was confused at times and had delusions about her husband. He stated that the resident's Parkinson's disease and dementia had progressed to the point that she had told him she was afraid would forget how to speak in English. Resident #37 was receiving medications twice a day for dementia with behaviors that included visual and auditory hallucinations.<br><br>During an interview with MDS Nurse #2 on 7/24/19 at 3:35 PM she stated that based on Resident #37's dementia diagnosis, there should | F 744 | be involved with this practice:<br>All current residents with diagnosis of dementia have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by Director of Nursing to ensure that all residents with diagnosis of dementia had a care plan implemented. All residents with diagnosis of dementia had a care plan implemented. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019 , the Director of Nursing in serviced all Nursing staff (Registered Nurses, Licensed practical nurse, and Nurse Aides: Full time, Part time and PRN) that the facility must ensure that A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing or Unit Manager will review 5 residents who have a diagnosis of dementia to ensure a care plan is implemented. This will be done on weekly | |

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| F 744 | Continued From page 57<br>have been a care plan in place to address her dementia care, and that it must have been an oversight.<br><br>During an interview with the Director of Nursing and the Administrator on 7/24/19 at 5:05 PM they both stated that it was their expectation that the resident's care plans be individualized to address care needs including dementia. | F 744 | basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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. | F 761 | | 8/22/19 |

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|---|---|---|---|---|
| F 761 | Continued From page 58<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interviews, and staff interviews, the facility failed to: 1) Discard expired medication in 1 of 2 medication storage rooms (Station 3 Med Room) observed; and, 2) Label medications with a shortened expiration date on 1 of 3 medication carts (300 Hall Med Cart) and in 1 of 2 medication storage rooms (Station 2 Med Room) observed..<br><br>The findings included:<br><br>1) Accompanied by Nurse #5, an observation was made of the Station 3 Medication Store Room on 7/22/19 at 3:05 PM. The observation revealed an opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the refrigerator. A hand-written date indicated the Tuberculin PPD medication was opened on 5/30/19. The manufacturer ' s labeling on the box containing the Tuberculin PPD solution read, in part: "Discard opened product after 30 days."<br><br>Accompanied by the facility ' s Director of Nursing (DON), a 2nd observation was made of the opened and expired Tuberculin PPD injectable medication stored in the Station 3 Medication | F 761 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F761 Label/Store drugs and Biologicals<br><br>Corrective Action:<br>Medication discarded from medication storage room and medications labelled with shortened expiration on 300 hall and station 2 med room.<br>Identification of other residents who may be involved with this practice:<br>All current residents with have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by Director of Nursing to ensure all expired medication | |

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| F 761 | Continued From page 59<br>Store Room on 7/22/19 at 3:18 PM. An interview was conducted with the DON at that time. Upon inquiry, the DON stated the tuberculin vial should not have been in the refrigerator as it was past the shortened expiration date indicated by the manufacturer.<br><br>2a) Accompanied by the facility ' s Director of Nursing (DON), an observation was made of the Station 2 Medication Store Room on 7/22/19 at 3:20 PM. The observation revealed two opened, multi-dose vials of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) were stored in the refrigerator. Neither of the Tuberculin PPD vials were dated to indicate when the medications were opened. The manufacturer ' s labeling on the boxes containing the Tuberculin PPD solution read, in part: "Discard opened product after 30 days."<br><br>An interview was conducted at the time of the observation on 7/22/19 at 3:20 PM with the DON. During the interview, the DON reported the opened vials of Tuberculin PPD injectable medication should have been dated to allow the determination of a shortened expiration date.<br><br>2b) Accompanied by Nurse Manager #1, an observation of the 300 Hall Medication Cart was conducted on 7/22/19 at 3:30 PM. The observation revealed an opened multi-dose vial of 200 milligram (mg) per 20 milliliter (ml) 1% lidocaine injectable medication (used as a local anesthetic) was stored on the med cart. The opened vial of lidocaine was not dated as to when it had been opened. When asked, the nurse stated she thought the vial of lidocaine was good up until the manufacturer ' s expiration date; she was not aware the medication would not have a | F 761 | was discarded and all medications with shortened expiration were labeled. All expired medications were discarded and all medications with a shortened expiration were labelled. This was completed on 8/19/2019.<br>Systemic Changes:<br>On 8/19/2019, the Director of Nursing in serviced all Nursing staff (Registered Nurses, Licensed practical nurse, and Nurse Aides: Full time, Part time and PRN) that 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.Storage of Drugs and Biologicals1) 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 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 in service was completed by 8/22/2019. Any nurse and nurse aide (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until | |

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| F 761 | Continued From page 60<br>shortened expiration date once it was opened. Multi-dose vials should be discarded 28 days after the first use, unless the manufacturer specifies otherwise. The manufacturer labeling on the lidocaine vial did not specify otherwise.<br><br>An interview was conducted on 7/23/19 at 8:05 AM with the facility ' s Director of Nursing (DON). During the interview, the medication storage observations were discussed and included the opened vial of 1% lidocaine injectable medication stored on a medication cart. The DON stated the opened vial of 1% lidocaine needed to be discarded. | F 761 | training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Director of Nursing or Unit Manager will observe all the medication carts and medication storage rooms to ensure that expired medications are discarded and all medication with a shortened expiration date are labelled. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2) | F 812 | | 8/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345284 | A. BUILDING _____ B. WING _____ | C 07/25/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE OAKS | 901 BETHESDA ROAD WINSTON SALEM, NC 27103 |

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| F 812 | Continued From page 61<br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring hair restraints were worn in the food preparation and food tray line areas; and by not ensuring all steamtable pans, sheet and muffin pans were stacked clean on the storage rack.<br><br>Findings included:<br><br>1. During a kitchen observation on 7/25/19 at 11:47 a.m., two men were in the kitchen during meal preparation, without hair restraints. The two men were observed working on the food processor in the food preparation area then, working on the ice machine located next to the steamtable during the tray line service in the | F 812 | The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F812 Food Procurement, Store/Prepare Serve Sanitary<br>Corrective Action:<br>Food Service Repair personnel working on the food processor and ice machine | |

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| F 812 | Continued From page 62<br>kitchen.<br><br>During an interview on 7/25/19 at 12:30 p.m., the Dietary Manager revealed the two men without hairnets in the kitchen were repairmen working on the food processer and the ice machine.<br><br>2. During a kitchen observation on 7/25/19 at 11:50 a.m., the following dirty, stainless steel pans were stacked on a storage rack consisting of cleaned dishware and pans: 1-6 inch deep pan with dried debris; 1-2 inch deep pan stained with a dried waxy substance; 1-4 inch deep pan with dried brown debris; 2-small sheet pans with brown debris; and 4-large muffin pans were greasy to touch and stained with brown debris.<br><br>During an interview on 7/25/19 at 12:30 p.m. the Dietary Manager acknowledged the pans were dirty, especially the muffin pans. She removed the pans to the dishwashing area of the kitchen to be rewashed. | F 812 | were notified of expectations to wear hair nets in the food preparation and food tray line on 8/19/19. Stainless steel pans and muffin pans were removed from storage rack on 7/25/19. New muffin pans ordered and delivered 8/5/19.<br>Identification of other residents who may be involved with this practice:<br>All current residents have the potential to be affected by the alleged practice. On 8/15/2019 through 8/19/2019 an audit was completed by Dietary Manager to ensure all pans are without debris and waxy substance. All pans cleaned/discarded. All food service workers and repair personnel were audited for compliance to wear hair restraint on 8/19/19. This was completed on 8/19/19.<br>Systemic Changes:<br>Corporate Registered Dietician and Dietary Manager in serviced all dietary workers Full Time and Part Time and PRN (as needed) on 7/26/19, 8/15/19 and 8/16/2019 of proper sanitation regulations and personal hygiene policy. Topics included Personal Employee Hygiene policy and Sanitation and Ware Washing Policy. Any dietary staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>Monitoring:<br>To ensure compliance, The Dietary | |

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| F 812 | Continued From page 63 | F 812 | Services Director will monitor compliance of personal hygiene policy and will complete Dietary inspection form 5 times weekly for 4 weeks then weekly for 2 months then monthly for 3 months. The Dietary Director or designee will complete the Dietary Audit Tool: Washing and Drying Techniques for 6 months. The results of this audit will be reviewed at the weekly Quality Assurance Team Meeting. Reports will be presented to the weekly Quality Assurance Committee by the Dietary Services Director to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. | |