

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2014
NAME OF PROVIDER OR SUPPLIER HIGHLAND HOUSE REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted a recertification health survey on 07/21/14 to 07/24/14. The survey team went back to the facility on 07/29/14 to 7/31/14 to gather additional information that led to the decision that the facility had substandard quality of care at the immediate jeopardy level. A partial extended survey was conducted on 7/29/14 through 07/31/14 and an exit conference was held with the facility on 07/31/14. The immediate jeopardy began on 4/4/14 and was removed on 7/31/14.	F 000			
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		8/8/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
08/22/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, physician assistant certified and physician interviews, the facility failed to notify the physician when the resident had severe pain and continued to have severe pain during turning, repositioning and wound care for 1 of 1 resident with a hip fracture (Resident #20). The immediate jeopardy began on 4/4/14 when the resident (Resident #20) with a right hip fracture was readmitted to the facility. The administrator was notified of the immediate jeopardy on 7/30/14 at 11:34 am. The immediate jeopardy was removed on 7/31/14 at 5:00 pm when the facility provided and implemented an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action.</p>	F 157	<p>F000 Disclaimer</p> <p>Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of</p>		

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F 157	<p>Continued From page 2</p> <p>Findings included:</p> <p>Resident #20 was readmitted to the facility on 4/4/14 with medical diagnoses including displaced femoral neck fracture (right hip fracture). The significant change Minimum Data Set (MDS) assessment dated 4/7/14 indicated Resident #20's mental status was severely impaired. "Other fracture" and received hospice care was indicated. The MDS assessment indicated the resident received a scheduled pain medication regimen with no complaints of pain during the review period. The care plan updated 4/17/14 documented the resident problem was pain. The goal stated for the problem was the resident pain will be relieved within one hour of intervention through next review. Interventions for the problem in part were pain medication as ordered, check positioning when complaining of pain, notify MD (medical doctor) if pain medication ineffective, offer pain medication prior to potentially pain-inducing procedures such as physical therapy, wound care. Review of the hospice plan of care did not reveal a plan for a hip fracture or pain.</p> <p>A review of the July 2014 physician orders revealed the following medications for pain: Oxycontin 10 milligrams (mg) by mouth twice a day dated 6/16/14 and Percocet 5/325mg one tablet by mouth twice a day as needed for pain dated 4/9/14. Review of the Medication Administration Record (MAR) for July 2014 revealed the last dose of Percocet 5/325 mg was administered on 7/23/2014 at 8:45 am.</p> <p>On 7/23/14 at 10:34 am prior to beginning wound care, the Wound Care Nurse stated the resident</p>	F 157	<p>future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. the HCFA-2567. The Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.</p> <p>F157</p> <p>It is the policy and normal practice of this facility to consult with the resident's physician when there is a change in the resident's physical status.</p> <p>Affected Residents:</p> <p>* Resident #20's attending physician and hospice physician were both notified of the pain status of this resident. The hospice physician was notified of the pain status on 07/23/14 and the attending physician was notified of the pain status on 07/24/14.</p> <p>* The attending physician also made a visit to the facility to assess the resident on 07/25/14.</p> <p>* Additional pain medication orders were</p>		

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F 157	<p>Continued From page 3</p> <p>normally complained of pain when being turned and stated the resident may yell out. During the observation of wound care, Resident #20 yelled out in pain multiple times when the Wound Care Nurse attempted alone to turn her onto her left side with the use of a cloth pad for the dressing change. Finally, the Wound Care Nurse stopped and returned with NA # 3. While the two staff members were turning Resident #20, the resident continued to yell out in pain. With the NA holding both hands on the resident's back, the Wound Care Nurse turned the resident to the left side with the use of the cloth pad and Resident #20 grabbed her right upper thigh and yelled "It hurt right there." The wound care nurse continued with wound care treatment. Immediately following the wound care at 10:43 am, the Wound Care Nurse was interviewed. She stated Resident #20 always complained of severe joint pain.</p> <p>On 7/23/14 at 10:50 am during an interview, Nurse # 2 stated it was normal for Resident #20 to cry out in pain when she was turned and repositioned.</p> <p>In an interview on 7/23/14 at 11:35 am, the Hospice Case Manager stated she was not aware that the resident was having pain with turning and repositioning.</p> <p>In an interview on 7/23/14 at 2:25 pm, NA # 3 (has worked with Resident #20 7-3 Monday through Friday since her readmission on 4/4/14) stated it was normal for Resident #20 to complain of pain when she was being turned and repositioned. She stated the resident always complained of pain on the right hip right where they said she had a fracture before. She stated</p>	F 157	<p>received on 07/23/14 for resident #20. The pain medication was increased to: (1) Oxycodone 10mg four times a day (prior order was for two times per day); (2) Percocet 5/325mg daily 30 minutes prior to wound treatment; and (3) Percocet every four hours as needed for pain.</p> <p>* Nursing staff is assessing pain every shift on this resident to ensure pain medication is effective and the resident is not demonstrating any signs/symptoms of pain. Beginning 07/23/14, all nursing staff (licensed & unlicensed) was instructed by the SDC, DoN, Administrator and Unit Director to report any increased signs/symptoms of pain to the Charge Nurse so that further interventions can be initiated if appropriate.</p> <p>Other Residents:</p> <p>* All other residents in the facility were reassessed on 07/30/14 by the QA, MDS, and DoN and will continue to be assessed for increased signs/symptoms of pain. If increased pain is identified and the current pain medication order is not effective, the physician will be notified by the unit nurse either by phone, fax or in person to obtain any further orders. No residents were found with untreated pain.</p> <p>Systemic Changes:</p> <p>* The SDC, DoN, Administrator and Unit Director beginning on 07/30/14 in-serviced all nursing staff (RNs, LPNs, CNAs) on the importance of reporting any increased signs/symptoms of pain to the Charge</p>		

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F 157	<p>Continued From page 4</p> <p>she had worked with the resident before on another hall before she went out to the hospital and was aware she had a fracture but she thought the fracture was healed. She stated when the resident was on the other hall she would get up out of bed. She further stated since the Resident #20 has been admitted to the current hall she do not get out of bed because it hurts too bad for you to move her.</p> <p>During a phone interview on 7/23/14 at 4:15 pm, the Hospice Case Manager stated she was not aware that Resident #20 had a hip fracture. Later, after reviewing the resident's admission paperwork for Hospice services, she stated the paperwork included a diagnosis of femoral neck fracture.</p> <p>On 7/23/14 at 4:35 pm during an interview, the Wound Care Nurse stated she was not aware Resident #20 still had a hip fracture. She stated she thought the fracture was healed. She further stated she was not aware of any recommendations by PT for safety precautions or instructions for two persons assist with bed mobility at all times for Resident #20.</p> <p>On 7/24/14 at 10:37 am during an interview, NA #3 stated she was not aware of any special precautions she should take when turning the resident. She further stated she always turned and repositioned the resident alone. NA#3 stated she did not tell the nurse about the resident complaining of pain to the right hip when turned and repositioned because everybody was aware.</p> <p>On 7/24/14 at 11:55am during an interview, Nurse #2 stated she was not aware Resident #20 had a right hip fracture. She acknowledged she</p>	F 157	<p>Nurse so that pain interventions can be initiated and the physician can be notified in a timely manner, if necessary.</p> <p>* The Physician Notification procedure changes are now included in the Orientation Process for all new licensed nursing staff.</p> <p>* Hospice staff (licensed & unlicensed) was in-serviced on 07/31/14 of changes and communication policy and procedures.</p> <p>* All facility staff (licensed & unlicensed) was in-serviced beginning 07/31/14 of hospice changes and hospice communication policy and procedures.</p> <p>* Hospice implemented on 07/31/14 an additional communication tool to enhance communication regarding change in status information to the facility and hospice staff.</p> <p>* Hospice will utilize their communication tool prior to leaving the facility to ensure that the Charge nurse has a report in reference to any hospice concerns to maintain continuity of care.</p> <p>QA Monitoring:</p> <p>* The DoN and/or designee will monitor the 24-hour Report Sheets and the Hospice Communication Reports to ensure that any reports of increased pain by any resident have been reported immediately to the attending physician and, in the case of hospice residents, to the hospice and that appropriate responses by the attending physician and/or hospice have been implemented to address reports of ongoing/increased</p>		

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F 157	<p>Continued From page 5</p> <p>completed the resident's admission assessment on readmission to the facility on 4/4/14. She further stated she did not implement any safety precautions related to a hip fracture for the resident. Nurse #2 stated she did not contact the doctor in reference to any safety precautions for the hip fracture because she did not know the resident had a hip fracture. After reviewing the hospital discharge summary dated 4/4/14, Nurse # 2 stated she must have overlooked the diagnosis.</p> <p>On 7/24/14 at 1:45 pm during a phone interview, Hospice NA #1 (who worked with Resident #20 since she was admitted to hospice services on 4/7/14) stated Resident #20 complained of right hip pain when she turned and repositioned her. She further stated she asked Nurse #2 and the Wound Care Nurse why the resident hollered so bad when you repositioned her when she first started working with the resident in April 2014. She stated she did not inform the Hospice Nurse because she was told the resident always complained of joint pain. The Hospice NA #1 stated the resident would holler when her right foot was touched. She further stated she always took care of the resident by herself. The Hospice NA stated the care she provided to the resident included bathing and turning and repositioning. She stated the resident always complained of pain when she repositioned her. The Hospice NA stated the resident has complained of pain since she started working with her in April 2014. She stated she was not aware the resident had a hip fracture. She further stated she was not aware of any safety precautions that she should take when working with Resident #20.</p> <p>On 7/24/14 at 1:57 pm, the Certified Occupational</p>	F 157	<p>pain. If any pertinent issues are identified (i.e. increased pain, change in condition, etc.) the charts will be reviewed to ensure the physician has been notified appropriately. This will be done at least four times per week for four weeks; weekly for four weeks; monthly for three months and then random audits, thereafter.</p> <p>* Results of the audit will be reported at the monthly Quality Assurance Committee meeting by the DoN or designee. Any instances of noncompliance with pain assessment and reporting protocols will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken immediately, up to and including employee discipline; additional training if needed and further review of existing pain assessment and reporting protocols and communication tools.</p>		

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F 157	<p>Continued From page 6</p> <p>Therapy Assistant (COTA) (who spoke on behalf of the Rehab Director ' s absence) stated she was unable to provide any written documentation of training to the staff related to the recommendations documented on the screening form dated 4/7/14. She further stated the Physical Therapist that completed the PT screening was no longer employed at the facility. The COTA stated the staff should do log rolling when turning Resident #20 with a right fracture to minimize the pain and discomfort to the resident.</p> <p>During an interview on 7/24/14 at 2:50 pm, NA #5 (has worked with Resident #20 on 3-11 shift Monday through Friday since her readmission on 4/4/14) stated Resident #20 complained of pain in her right leg daily when turned and repositioned. She further stated she was not aware that the resident had a right hip fracture or of any special precautions to take when the resident was turned.</p> <p>On 7/24/14 at 3:04 pm in an interview, Nurse #1(has worked with Resident #20 on 3-11 shift Monday through Friday since she was readmitted to the facility on 4/4/14) stated she was not aware that Resident #20 had a hip fracture. She further stated she was aware that the resident yelled and complained of pain when being turned. Nurse #1 stated she thought this was normal for the resident since when was readmitted to the facility on 4/4/14.</p> <p>During an interview on 7/24/14 at 6:05 pm, the Director of Nursing (DON) stated it was her expectation for the hall nurse to address the resident ' s complaint of pain with medication or any other intervention that may be appropriate. She further stated if the interventions were attempted and not effective, it was her</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>expectation for the nurse to get on the phone and notify the physician immediately. She further stated she expected the staff to stop the procedure if a resident was complaining of pain until the pain was under control. The DON stated it was her expectation for the staff to ensure the resident made it to her scheduled appointment. She stated she was not aware of what happened in this case that resulted in the resident not going to her scheduled follow up appointment on April 15, 2014.</p> <p>On 7/29/14 at 4:07 pm in an interview, the Physician Assistant Certified #1 (PA-C) for the local orthopaedic office stated it was his expectation for the facility to arrange for the resident to attend the scheduled follow up appointment on 4/15/14. The PA-C stated the plan for the follow up appointment that was scheduled for April 15, 2014 was to repeat the X-rays to see if there were any changes. The PA-C stated if the resident would have been seen at the earlier appointment date and changes were noted, treatment could have been initiated sooner. He stated failure to provide safety measures or protective handling for a resident with a hip fracture could result in increased pain to the resident or displacement of the fracture. He further explained safety measures would include supporting the affected extremity and log rolling.</p> <p>On 7/30/14 at 9:45 am during an interview, the orthopaedic PA-C #1 stated his evaluation of the patient and the most recent X-rays on 7/29/14 revealed Resident #20 was experiencing excruciating pain. He stated there has been a significant decline in the condition of the resident 's right hip. The PA-C stated surgery was now recommended to help alleviate the pain even</p>	F 157			

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F 157	<p>Continued From page 8 though the resident was a high risk surgical candidate.</p> <p>During a family interview on 7/30/14 at 2:25 pm, the Power of Attorney stated he was not aware the resident had missed her follow up appointment. He stated he wanted the bone doctor to keep a check on the resident ' s hip because she was having so much pain with it. He stated he has been in to visit the resident and has seen how much pain she was having especially when she was being moved by the staff.</p> <p>In a phone interview on 7/31/14 at 10:30 am, the attending physician stated it was his expectation for the facility to handle the resident with care. He further stated it was his expectation for the facility to notify him if the resident was experiencing still experiencing pain with the current medication regimen. The attending physician stated he would have ordered pain medication to be given before turning and repositioning or whatever was indicated at the time to make the resident comfortable. The attending physician stated he was not aware of the follow up appointment with the orthopaedic office that was scheduled for April 15, 2014. He stated it was his expectation for the facility to honor the wishes of the resident or Power of Attorney (POA) at all times.</p> <p>In an interview on 7/31/14 at 11:35 am, the Hospice Case Manager stated it was her expectation for the hospice NA to notify the facility nurse first if a resident was experiencing pain. She further stated she expected the NA to notify the case manager for hospice also if a resident complained of pain during the time care was provided to the resident.</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>The facility provided the following Credible Allegation on July 31, 2014 at 5:00 pm.</p> <p>F157</p> <p>It is the policy of this facility to consult with the resident ' s physician when there is a change in the resident ' s physical status.</p> <p>Corrective Action for Identified Resident-</p> <ul style="list-style-type: none"> · Resident #20's attending physician and hospice physician were both notified of the pain issues for this resident. The hospice physician was notified on 7/23/14 and the attending physician was notified on 7/24/14. The attending physician also made a visit to the facility to assess the resident on 7/25/14. · Additional pain medication orders were received on 7/23/14 for Resident #20. The pain medication was increased to: 1. Oxycodone 10mg four times a day (prior order was for two times per day); 2. Percocet 5/325mg daily 30 minutes prior to wound treatment; and 3) Percocet every four hours as needed for pain. · Nursing staff is assessing pain every shift on this resident to ensure pain medication is effective and the resident is not demonstrating any signs/symptoms of pain. Beginning 7/23/14, all nursing staff (licensed & unlicensed) have been instructed by the SDC, DoN, Administrator and Unit Director to report any increased signs/symptoms of pain to the Charge Nurse so that further interventions can be initiated if appropriate. Anyone still needing in-servicing will be in-serviced prior to working their next scheduled shift. <p>Id & Corrective Action of other residents having the potential to be affected-</p>	F 157			

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F 157	<p>Continued From page 10</p> <ul style="list-style-type: none"> · All other residents in the facility were assessed on 07/30/14 by QA, MDS and DoN and will continue to be assessed for increased signs/symptoms of pain. If increased pain is identified and the current pain medication order is not effective, the physician will be notified by the unit nurse either by phone, fax or in person to obtain any further orders. No other residents were found with untreated pain. · The SDC, DoN, Administrator and Unit Director beginning on 07/30/14 in-servicing all nursing staff (RNs, LPNs, CNAs) on the importance of reporting any increased signs/symptoms of pain to the Charge Nurse so that pain interventions can be initiated and the physician can be notified in a timely manner, if necessary. All but 4 have been in-serviced. Anyone still needing in-servicing will be in-serviced prior to working their next scheduled shift. · Hospice implemented on 7/31/14 an additional communication tool to enhance communication regarding change in status information to the facility and hospice staff. Tool will be provided by hospice prior to leaving. · Hospice staff (licensed & unlicensed) were in-serviced on 07/31/14 of changes and communication policy & procedures. · Facility staff (licensed & unlicensed) were in-serviced on 07/31/14 of hospice changes and hospice communication policy & procedures. Anyone still needing in-servicing will be in-serviced prior to working their next scheduled shift. <p>Completion Date: 07/31/14</p> <p>On 7/31/2014 at 5:30 pm, verification of the credible allegation was evidenced by interviews of</p>	F 157			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 157	Continued From page 11 licensed nursing staff related to the notification to the physician for residents experiencing pain without relief. Verification of the credible allegation continued with interviews of unlicensed nursing staff related to reporting pain to the licensed nurse. The unlicensed nursing staff verified the need to notify the nurse for any complaint of pain by a resident so the resident can be checked by the nurse or medicated for the pain. Verification of the credible allegation was also continued with interviews of the hospice staff related to the new communication form for the exchange of information between the facility and hospice related to any changes or concerns of the resident ' s condition.	F 157			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		8/27/14	

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F 272	<p>Continued From page 12 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to accurately assess the comprehensive needs of a resident for 1 of 1 resident (resident # 81) reviewed for dialysis. Findings included:</p> <p>Resident #81 was admitted to the facility on 5/15/13 and readmitted on 6/23/14 with a diagnosis of end stage renal disease (ERSD). Dialysis was scheduled for Tuesdays, Thursdays and Saturdays per physician ' s orders.</p> <p>The most recent annual comprehensive Minimum Data Set (MDS) assessment was completed 3/30/14. This assessment indicated Resident #81 had severe cognitive impairment and required total assistance with his activities of daily living (ADLs) except for eating. He was coded for dialysis but dialysis was not addressed in the</p>	F 272	<p>F272</p> <p>It is the policy and normal practice of this facility to conduct initially and periodically, a comprehensive, accurate, standardized and reproducible assessment of each resident's functional capacity and to accurately assess the comprehensive needs of each resident.</p> <p>Affected Residents:</p> <p>* Resident #81's plan of care was reviewed and revised by the Care Plan Coordinator on 7/22/2014 and to address dialysis needs. * The care guide of Resident #81 was reviewed and revised by the Care Plan Coordinator on 07/22/2014 and now</p>		

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F 272	<p>Continued From page 13</p> <p>Care Area Assessment (CAA) of the MDS. The only other MDS noted on Resident #81 was a discharge MDS with return anticipated dated 6/14/14.</p> <p>In an interview on 7/22/14 at 3:45 PM, the MDS Nurse #1 stated that the annual comprehensive assessment should have captured the dialysis on the CAA and been care planned with the precautions specific for a dialysis resident.</p> <p>In an interview on 7/22/14 at 4:50 PM, nursing assistant (NA) #1 stated the staff followed what was on the resident status sheet located in each resident closet to know how to care for their assigned residents. A review of Resident #81's status sheet made no mention of specific precautions or assessments for a dialysis resident.</p> <p>In an interview on 7/22/14 at 4:53 PM, Nurse #1 stated Resident #81 went to dialysis on first shift and returned on her shift. She stated the dialysis center was expected to send the dialysis communication form back with Resident #81 but they often did not. Nurse #1 stated she did not routinely follow up on the form but the clinic would call if there was a complication with Resident #81. When questioned regarding any dialysis specific care she completed for Resident #81 after a treatment, Nurse #1 stated the aides would lay Resident #81 down and offered him dinner.</p> <p>In an interview on 7/22/14 at 5:00 PM, the Director of Nursing (DON) stated the MDS Nurses were responsible to the accuracy of the comprehensive assessments which generated the care plan and resident status sheets.</p>	F 272	<p>indicates dialysis interventions for this resident.</p> <p>* Beginning 7/22/2014, all staff was in-serviced by the Staff Development Coordinator on the care of this resident related to dialysis needs.</p> <p>Other Residents:</p> <p>* The Care Plans of all other residents were reviewed and revised, beginning 07/22/2014 if appropriate, by the Care Plan Team to ensure they were up to date and interventions implemented.</p> <p>Systemic Changes:</p> <p>* Care Plans have been removed from a separate binder and are now being placed in each resident's individual charts. This has been communicated to all licensed hospice and facility nursing staff by the Staff Development Coordinator.</p> <p>* On 07/22/2014 the MDS Coordinator was instructed by the DoN to ensure that all residents who receive dialysis have a dialysis care plan in place.</p> <p>* Although dialysis services do not trigger a CAA, the MDS Coordinator is reviewing all charts to identify any residents receiving dialysis. A dialysis care plan will be implemented for all residents receiving dialysis.</p> <p>* Care plans are being reviewed and updated by the Care Plan Team at all weekly scheduled clinical meetings.</p> <p>* The MDS Coordinator will continue to ensure that all triggered CAAs are addressed and care planned as</p>		

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F 272	<p>Continued From page 14</p> <p>In an interview on 7/22/14 at 5:00 PM, the administrator stated she would have expected the MDS nurses to have completed the MDS assessment accurately in order to ensure the care was being delivered to resident #81 safely and that the staff to knew how to care for dialysis resident.</p> <p>In an observation on 7/22/14 at 5:10 PM, Resident #81 was observed in bed. He had just returned from dialysis. There was an observed dry dressing to his left lower arm. He was easily aroused and appeared in no distress.</p> <p>In an interview on 7/23/14 at 8:40 AM, NA #2 stated she had not received training from the facility about the care of a dialysis shunt or the care a dialysis resident. NA #2 stated she was told to refer to the resident status sheet to see how to care for Resident #81. NA #2 reviewed Resident #81's resident status sheet in his closet and stated there was nothing indicating Resident #81 was a dialysis resident or that he had a dialysis shunt in his arm. NA #2 stated resident #81 would not be able to communicate that information based on his cognition. In an observation at this time, Resident #81 was sitting up in bed with a dry dressing observed to his left lower forearm. He was pleasantly confused and unable to have a meaningful conversation.</p> <p>In an interview on 7/23/14 at 9:00 AM, NA #3 stated she unaware how to care for dialysis shunt and was unaware how to manage emergencies and complications.</p> <p>In an interview on 7/23/14 at 10:30 AM, the MDS Nurse #2 stated she neglected to complete a CAA and care plan for Resident #81 at the time of</p>	F 272	<p>appropriate for each resident.</p> <ul style="list-style-type: none"> * The 24-hour Report Sheet has been revised to include a section that indicates dialysis and any changes in dialysis care. * The Interim Care Plan was also revised to reflect dialysis needs for any new admission to the facility. * Orders and progress notes will continue to be reviewed in the morning clinical meeting by the ADoN, MDS Coordinator, DoN, Wound Nurse, QA Nurse and care plans will continue to be updated when appropriate. * All licensed nursing staff was in-serviced beginning 7/22/2014 by the SDC regarding care plans and care guides. <p>Quality Assurance:</p> <ul style="list-style-type: none"> * The DoN and/or designee will audit the care plans of all new admissions on a weekly basis to ensure pertinent care plans are in place. In addition, care plans will be systematically audited during the weekly clinical meetings to ensure they are up to date and appropriate. This will be done on an ongoing basis. * The DON and/or designee will audit the care plans of all residents receiving dialysis to ensure that a care plan is in place. This will be ongoing as new dialysis residents are admitted to the facility. * Results of the audit will be reported monthly to the Quality Assurance Committee. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and 		

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F 272	Continued From page 15 his annual assessment. She stated there had been a lot of turn over in the MDS office and a change in the computer system in April that could have resulted in the lack of an accurate assessment. In an interview on 7/24/14 at 9:00, Nurse #2 stated resident #81 went to dialysis on her shift and she made sure the dialysis communication form went with him in his lunch bag for each treatment. Nurse #2 stated he returned on second shift and the second shift nurse would ensure the form returned with him. Nurse # 2 stated she applied lidocinae to his shunt before his treatments and palpated for a thrill to his shunt prior to the medication application. In another interview on 7/24/14 at 10:25 AM, the administrator and the DON stated MDS Nurse #2 was accountable for the accuracy of the MDS assessment and the CAA's should have been completed on the annual MDS completed on 3/30/14 and the care plan completed with the resident status sheet updated to ensure dialysis specific care was communicated.	F 272	responsive action will be taken.		
F 279 SS=K	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		8/27/14	

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F 279	Continued From page 16 The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician assistant certified (PA-C) interviews, the facility failed to develop a care plan for a resident (Resident #20) with a right hip fracture and hospice care which resulted in the nursing staff not knowing the resident had a hip fracture, which resulted in the staff not using safety, precautionary or supportive measures when turning and repositioning the resident during care as recommended by the Physical Therapist (PT) which resulted in increased pain for the resident when turned and repositioned (Resident #20). The facility also failed to care plan a resident for dialysis services (resident #81) for 2 of 21 residents reviewed for care planning. The immediate jeopardy began on 4/4/14 when a resident (Resident #20) with a right hip fracture was readmitted to the facility and the facility failed to initiate a care plan for a hip fracture. The administrator was notified of the immediate jeopardy on 7/30/14 at 11:34 am. The immediate jeopardy was removed on 7/31/14 at 5:00 pm when the facility provided and implemented an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a	F 279	F279 It is the policy and normal practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to ensure services are furnished to attain or maintain the resident's highest practicable well-being. Affected Residents: * The care plan for Resident #20 was updated on 07/25/14 and again on 07/30/14 to address the hospice status & care, hip fracture and breakthrough pain. This includes measurable objectives and timetables. Plans were developed, reviewed and initiated by the Care Plan Team. * The hospice nurse revised the hospice care plan on 07/31/14. The hospice care plan and facility care plan were coordinated with facility MDS Coordinator. * Beginning 07/25/14 all nursing staff		

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F 279	<p>Continued From page 17</p> <p>scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Example #2 is at a scope and severity of D.</p> <p>Findings included:</p> <p>1. Resident #20 was readmitted to the facility on 4/4/14 with medical diagnoses including displaced femoral neck fracture (right hip fracture), osteopenia and osteoarthritis. The significant change Minimum Data Set (MDS) assessment dated 4/7/14 indicated Resident #20's mental status was severely impaired. The same assessment documented Resident #20 had "other fracture" and received hospice care during the review period.</p> <p>Review of the "Therapy Services Screening" dated 4/7/14 in the medical record documented in part "Patient (pt) is maximum (max) assist X2 with bed mobility. Pt needs to remain in bed with X 2 assist for all mobility to avoid compromise of RLE (right lower extremity) fx (fracture)."</p> <p>On 7/23/14 at 10:34 am prior to beginning wound care, the Wound Care Nurse stated the resident normally complained of pain when being turned and stated the resident may yell out. During the observation of wound care, Resident #20 yelled out in pain multiple times when the Wound Care Nurse alone attempted to turn her onto her left side with the use of a cloth pad for the dressing change. Finally, the Wound Care Nurse stopped and returned with NA #3. While the two staff members were turning Resident #20, the resident continued to yell out in pain. With the NA holding</p>	F 279	<p>(licensed & unlicensed) including hospice staff providing care for Resident #20 were in-serviced on the interventions in Resident #20's plan of care by DoN, ADoN, SDC, and Administrator. The care plan changes were communicated to nursing and hospice staff (licensed & unlicensed) verbally, by instruction sheet, and via the Care Guide, which is placed in each resident's room.</p> <p>* Resident #81's plan of care was reviewed and revised by the Care Plan Coordinator on 7/22/2014 to include dialysis needs.</p> <p>* The care guide of Resident #81 was reviewed and revised by the Care Plan Coordinator to indicate dialysis interventions for this resident.</p> <p>* All staff was in-serviced beginning 7/22/14 by the Staff Development Coordinator regarding the care of this resident related to dialysis needs.</p> <p>Other Residents:</p> <p>* Beginning 7/22/2014 the Care Plans of all other residents were reviewed, and if appropriate revised, by the DoN, ADoN, Care Plan Coordinator and QA Nurse, to ensure they were up to date and interventions implemented where appropriate.</p> <p>* DoN, MDS, QA Nurse and Unit Director reviewed on 07/30/14 care plans of other residents with any type of "injury" issues to ensure that appropriate care plans were in place. This was accomplished by chart review and actual pain assessment. The Unit Nurse is responsible for initiating</p>		

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F 279	<p>Continued From page 18</p> <p>both hands on the resident's back, the Wound Care Nurse turned the resident to the left side with the use of the cloth pad and Resident #20 grabbed her right upper thigh and yelled "It hurt right there." The Wound Care Nurse continued with wound care treatment. Immediately following the wound care at 10:43 am, the Wound Care Nurse was interviewed. She stated Resident #20 always complained of severe joint pain.</p> <p>On 7/23/14 at 10:50 am during an interview, Nurse #2 stated it was normal for Resident #20 to cry out in pain when turned and repositioned.</p> <p>In an interview on 7/23/14 at 11:35 am, the Hospice Case Manager stated she was not aware that the resident was having pain with turning and repositioning.</p> <p>In an interview on 7/23/14 at 2:25 pm, NA #3 (has worked with Resident #20 7-3 Monday through Friday since her readmission on 4/4/14) stated it was normal for Resident #20 to complain of pain when she was being turned and repositioned. She stated the resident always complained of pain on the right hip right where they said she had a fracture before. She stated she had worked with the resident before on another hall before she went out to the hospital and was aware she had a fracture but she thought the fracture was healed. She stated when the resident was on the other hall she would get up out of bed. She further stated since the Resident #20 has been admitted to the current hall she do not get out of bed because it hurts too bad for you to move her.</p> <p>During a phone interview on 7/23/14 at 4:15 pm, the Hospice Case Manager stated she was not aware that Resident #20 had a hip fracture. Later,</p>	F 279	<p>changes to the pain care plan via the 24hr. shift report and Nurse-to-Nurse Report Sheet. No other residents were identified.</p> <p>* The MDS Coordinator on 07/29/14 reviewed all charts of residents receiving hospice services to ensure a care plan is in place. All other residents receiving hospice services have an appropriate hospice care plan.</p> <p>* The MDS Coordinator reviewed all other care plans of residents in the facility currently on dialysis to ensure a care plan is in place. All other residents receiving dialysis have an appropriate dialysis care plan in place.</p> <p>* The MDS Coordinator also reviewed the care guides of all residents in the facility receiving dialysis and were updated to communicate dialysis needs to the staff caring for these residents.</p> <p>Systemic Changes:</p> <p>* All licensed nursing staff was in-serviced beginning 7/22/14 by the Staff Development Coordinator regarding care plans and care guides.</p> <p>* Hospice implemented on 07/31/14 an additional communication tool to enhance communication regarding change in status information to the facility and hospice staff.</p> <p>* Hospice staff prior to leaving the facility will provide the communication tool to the Charge Nurse.</p> <p>* Hospice will utilize their communication tool prior to leaving the facility to ensure that the Charge Nurse has a report in</p>		

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F 279	<p>Continued From page 19</p> <p>after reviewing the resident's admission paperwork for Hospice services, she stated she the paperwork included a diagnosis of femoral neck fracture.</p> <p>On 7/23/14 at 4:35 pm during an interview, the Wound Care Nurse stated she was not aware Resident #20 still had a hip fracture. She stated she thought the fracture was healed. She further stated she was not aware of any recommendations by PT for safety precautions or instructions for two persons assist with bed mobility at all times for Resident #20.</p> <p>On 7/24/14 at 10:37 am during an interview, NA #3 stated she was not aware of any special precautions she should take when turning the resident. She further stated she always turned and repositioned the resident alone. NA#3 stated she did not tell the nurse about the resident complaining of pain to the right hip when turned and repositioned because everybody was aware.</p> <p>On 7/24/14 at 11:55am during an interview, Nurse #2 stated she was not aware Resident #20 had a right hip fracture. She acknowledged she completed the resident ' s admission assessment on readmission to the facility on 4/4/14. She further stated she did not implement any safety precautions related to a hip fracture for the resident. Nurse #2 stated she did not contact the doctor in reference to any safety precautions for the hip fracture because she did not know the resident had a hip fracture. After reviewing the hospital discharge summary dated 4/4/14, Nurse # 2 stated she must have overlooked the diagnosis.</p> <p>On 7/24/14 at 1:45 pm during a phone interview,</p>	F 279	<p>reference to any hospice concerns that may need to be addressed in the care plan to maintain continuity of care.</p> <p>* The MDS Coordinator is reviewing all charts to identify any residents receiving dialysis. A dialysis care plan will be implemented for all residents receiving dialysis.</p> <p>* The 24-hour Report Sheet was revised to include a section that indicates dialysis and changes in dialysis care.</p> <p>* The Interim Care Plan was also revised to reflect dialysis needs for any new admission to the facility.</p> <p>* It is now the policy of this facility that all residents will have a pain care plan in place on admission. The pain care plan will include measurable objectives and timetables to ensure all pain issues in the facility are being addressed in a timely and effective manner. MDS nurse will review quarterly and as needed all pain care plans to ensure they are up to date and appropriate.</p> <p>* Care Plans have been removed from a separate binder and are now being placed in each resident's individual charts. This has been communicated to all licensed hospice and facility nursing staff by the Staff Development Coordinator.</p> <p>* The Interim Care Plan was reviewed and revised on 7/30/14 to ensure interventions are included that address any type of injury, fracture, etc., for any resident who is admitted to the facility with such an injury/fracture.</p> <p>* All nursing staff, including hospice staff is now being made aware of any updates to the care plans related to pain, injury,</p>		

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F 279	<p>Continued From page 20</p> <p>Hospice NA #1 (who worked with Resident #20 since she was admitted to hospice services on 4/7/14) stated Resident #20 complained of right hip pain when she turned and repositioned her. She further stated she asked Nurse #2 and the Wound Care Nurse why the resident hollered so bad when you repositioned her when she first started working with the resident in April 2014. She stated she did not inform the Hospice Nurse because she was told the resident always complained of joint pain. The Hospice NA #1 stated the resident would holler when her right foot was touched. The Hospice NA stated she always took care of the resident by herself. She further stated the care she provided to the resident included bathing and turning and repositioning. She stated the resident always complained of pain when she repositioned her. The Hospice NA stated the resident has complained of pain since she started working with her in April 2014. She stated she was not aware the resident had a hip fracture. She further stated she was not aware of any safety precautions that she should take when working with Resident #20.</p> <p>On 7/24/14 at 1:57 pm, the Certified Occupational Therapy Assistant (COTA) (who spoke on behalf of the Rehab Director's absence) stated she was unable to provide any written documentation of training to the staff related to the recommendations documented on the screening form dated 4/7/14. She further stated the Physical Therapist that completed the PT screening was no longer employed at the facility. The COTA stated the staff should do log rolling when turning Resident #20 with a right fracture to minimize the pain and discomfort to the resident.</p> <p>During an interview on 7/24/14 at 2:50 pm, NA #5</p>	F 279	<p>hospice or any other pertinent issues via the 24hr Report Sheet and Care Guide (which is placed in each resident's room).</p> <p>* The Administrator, MDS Nurse, DoN, ADoN, QA Nurse and Unit Director were in-serviced by Nurse Consultant, RN, RAC (Resident Assessment Certification) on 7/31/14, on care plan development and updates that include, but not limited to (1) care plans should be consistent with resident's specific conditions, risks, needs, etc. and current standards of practice and (2) the need to include measurable objectives, approximate timetables, specific interventions and/or services needed to address those needs and conditions and (3) the process for reviewing and revising the care plan periodically as necessary.</p> <p>Quality Assurance:</p> <p>* The DoN and/or designee will audit the care plans of all new admissions on a weekly basis to ensure pertinent care plans are in place. In addition, care plans of existing residents will be systematically audited during the various weekly interdisciplinary meetings to ensure they are up to date and appropriate and are coordinated with hospice plans of care. This will be done on an ongoing weekly basis.</p> <p>* The DON or designee will audit the care plans of all residents receiving dialysis to ensure that a dialysis care plan is in place. This will be ongoing as new dialysis residents are admitted to the facility.</p>		

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F 279	<p>Continued From page 21</p> <p>(has worked with Resident #20 on 3-11 shift Monday through Friday since her readmission on 4/4/14) stated Resident #20 complained of pain in her right leg daily when turned and repositioned. She further stated she was not aware that the resident had a right hip fracture or of any special precautions to take when the resident was turned.</p> <p>On 7/24/14 at 3:04 pm in an interview, Nurse #1 (has worked with Resident #20 on 3-11 shift Monday through Friday since she was readmitted to the facility on 4/4/14) stated she was not aware that Resident #20 had a hip fracture. She further stated she was aware that the resident yelled and complained of pain when being turned. Nurse #1 stated she thought this was normal for the resident since when was readmitted to the facility on 4/4/14.</p> <p>On 7/24/14 at 4:35 pm during an interview, the MDS Nurse #1 acknowledged there was no care plan for Resident #20 related to the right hip fracture and hospice care. The MDS nurse further indicated the care plan should have been updated to include goals and interventions related to the hip fracture and hospice care. She further stated she was not aware the resident had a hip fracture.</p> <p>During an interview on 7/24/14 at 6:05 pm, the Director of Nursing (DON) stated it was her expectation for the hall nurse to complete an interim care plan upon the resident's admission or readmission to the facility. She further stated she expected the nurse to transfer the care plan information to the care guide for the NA's (Nursing Assistants) to have as a reference when providing care to the resident.</p>	F 279	* Results of the audit will be reported monthly to the Quality Assurance Committee by the DoN. Any instances of noncompliance with the requirement that care plans be: (1) created upon admission; (2) regularly updated and (3) maintained in an accurate and current status will be analyzed to determine when such noncompliance occurred, why and how. Appropriate responses will be initiated up to and including employee discipline and training, as needed.		

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F 279	<p>Continued From page 22</p> <p>On 7/29/14 at 4:07 pm in an interview, the Physician Assistant Certified (PA-C) for the local orthopaedic office stated failure to provide safety measures or protective handling for a resident with a hip fracture could result in increased pain to the resident or displacement of the fracture. He further explained safety measures would include supporting the affected extremity and log rolling.</p> <p>On 7/30/14 at 9:45 am during an interview, the orthopaedic PA-C stated his evaluation of the patient and the most recent X-rays on 7/29/14 revealed Resident #20 was experiencing excruciating pain. He stated there has been a significant decline in the condition of the resident's right hip. The PA-C stated surgery was now recommended to help alleviate the pain even though the resident was a high risk surgical candidate.</p> <p>In an interview on 7/31/14 at 11:35 am, the Hospice Case Manager acknowledged the hospice plan of care for Resident #20 did not address the right hip fracture or pain. She further stated she has not reviewed Resident #20's plan of care for any needed revisions or for validation with the facility's care plan since the resident was admitted to hospice services on 4/7/14.</p> <p>The facility provided the following Credible Allegation on July 31, 2014 at 5:00pm.</p> <p>F279 It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to ensure services are furnished to attain or maintain the resident ' s highest practicable well-being.</p>	F 279			

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F 279	Continued From page 23 Corrective Action for Identified Resident- <ul style="list-style-type: none"> · The care plan for Resident #20 was updated on 07/25/14 and again on 7/30/14 to address the hospice status & care, hip fracture and breakthrough pain that includes measurable objectives and timetables. Plans were developed, reviewed and initiated by the Care Plan Team. · The hospice care plan was revised on 7/31/14 by the hospice nurse. The hospice care plan and facility care plan were coordinated with facility MDS Coordinator. · Beginning 07/25/14 all nursing staff (licensed & unlicensed) including hospice staff providing care for Resident #20 were in-serviced on the interventions in Resident #20's plan of care by DoN, ADoN, SDC, and Administrator. The care plan changes were communicated to nursing and hospice staff (licensed & unlicensed) verbally, by instruction sheet, and via the Care Guide which is placed in each resident 's room. Id & Corrective Action of other residents having the potential to be affected- <ul style="list-style-type: none"> · Care plans of other residents with any type of " injury " issues have been reviewed by DoN, MDS, QA and unit director on 07/30/14 to ensure that appropriate care plans were in place. This was accomplished by chart review and actual pain assessment. The unit nurse is responsible for the initiating changes to the pain care plan via the 24-hour shift report and Nurse to Nurse Report Sheet. No other residents were identified. · It is now the policy of this facility that all residents will have a pain care plan in place on admission. The pain care plan will include measurable objectives and timetables to ensure all pain issues in the facility are being addressed in a timely and effective manner. All pain care 	F 279			

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F 279	Continued From page 24 plans will be reviewed by MDS nurse quarterly and as needed to ensure they are up to date and appropriate. · All charts were reviewed of residents receiving hospice services to ensure a care plan is in place by the MDS Coordinator on 7/29/14. All other residents receiving hospice services have an appropriate hospice care plan. Hospice implemented on 7/31/14 an additional communication tool to enhance communication regarding change in status information to the facility and hospice staff. Communication tool will be provided by hospice staff prior to leaving. · The Interim Care Plan form was reviewed and revised on 07/30/14 to ensure interventions are included to address any type of injury, fracture, etc. for which a resident is admitted with. · All nursing staff including hospice staff will be made aware of any updates to the care plans related to pain, injury, hospice or any other pertinent issues via the Nurse to Nurse Report Sheet and the Care Guide which is placed in each resident ' s room. Hospice implemented on 7/31/14 an additional communication tool to enhance communication regarding change in status information to the facility and hospice staff. Communication tool will be provided by hospice staff prior to leaving. · The Administrator; MDS, DoN, ADoN, QA nurse, and unit director were in-serviced by Nurse Consultant, RN, Resident Assessment Certification (RAC) on 07/31/14 on care plan development and updates that include but not limited to (1) care plans should be consistent with resident ' s specific conditions, risks, needs, etc. and current standards of practice and (2) the need to include measurable objectives, approximate timetables, specific interventions and/or services needed to address those needs	F 279			

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F 279	<p>Continued From page 25 and conditions, and 3) the process for reviewing and revising the care plan periodically as necessary.</p> <p>Completion Date: 7/31/2014</p> <p>On 7/31/2014 at 5:30 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff related to the implementation of an interim care plan on all residents admitted to the facility. Licensed Nurse, the Hospice Case Manager and MDS nurses verified the updates and implementation of care plans will be communicated the staff via the Nurse to Nurse report. Verification of the credible allegation continued with interviews of unlicensed nursing staff related to the new communication of updates or implementation of a care plan via the care guide. The unlicensed staff verified the location of the document and what they should do if they have any questions as it relate to any resident at any time while caring for the resident.</p> <p>2. Resident #81 was admitted to the facility on 5/15/13 and readmitted on 6/23/14 with a diagnosis of end stage renal disease (ERSD). Dialysis was scheduled on Tuesday, Thursday and Saturdays per physician's orders.</p> <p>The annual Minimum Data Set (MDS) completed 3/30/14 indicated Resident #81 had severe cognitive impairment and required total assistance with his activities of daily living (ADLs) except for eating. There was no care plan for his dialysis shunt precautions, assessment, complications or potential emergencies.</p> <p>A review of the medical record revealed the last</p>	F 279			

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F 279	<p>Continued From page 26</p> <p>dialysis communication form was completed on 7/15/14 and the last nursing note was completed on 7/12/14 on Resident #81. The dialysis communication form indicated that the dialysis staff were to obtain and pre and post weight and a post blood pressure on Resident #81. There was a place for dialysis staff to indicate any abnormal findings, treatments, medications or any new orders or changes that may have occurred during the dialysis treatment. There was no place on the form for facility staff to document any assessment or monitoring following Resident #81 ' s return to the facility after his treatment.</p> <p>In an interview on 7/22/14 at 4:50 PM, nursing assistant (NA) #1 stated she was not educated on the care of a dialysis resident but stated she was a medic and knew the precautions necessary for a dialysis resident. NA #1 stated she was unaware of the facility's expectation regarding the care of Resident #81 but the staff was instructed to follow what was on the resident status sheet located in each resident closet for specific care information. A review of Resident #81 ' s status sheet made no mention of specific precautions or assessments for a dialysis resident.</p> <p>In an interview on 7/22/14 at 4:53 PM, Nurse #1 stated Resident #81 went to dialysis on first shift and returned on her shift. She stated the dialysis center was expected to send the dialysis communication form back with Resident #81 but they often did not. Nurse #1 stated she did not routinely follow up on the form but the clinic would call if there was a complication with Resident #81. When questioned regarding any dialysis specific care she completed for Resident #81 after a treatment, Nurse #1 stated the aides would lay Resident #81 down and offered him dinner.</p>	F 279			

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F 279	<p>Continued From page 27</p> <p>Nurse #1 stated she would refer to the care plan to know handle complications, emergencies or precautions.</p> <p>In an interview on 7/23/14 at 8:40 AM, NA #2 stated she had not received training from the facility about the care of a dialysis shunt or the care a dialysis resident. NA #2 stated she was told to refer to the resident status sheet to see how to care for Resident #81. NA #2 reviewed Resident #81's resident status sheet in his closet and stated there was nothing indicating Resident #81 was a dialysis resident or that he had a dialysis shunt in his arm. NA #2 stated resident #81 would not be able to communicate that information based on his cognition. In an observation at this time, Resident #81 was sitting up in bed with a dry dressing observed to his left lower forearm. He was pleasantly confused and unable to have a meaningful conversation.</p> <p>In an interview on 7/23/14 at 9:00 AM, NA #3 stated she unaware how to care for dialysis shunt and was unaware how to manage emergencies and complications.</p> <p>In an interview on 7/23/14 at 10:30 AM, the MDS Nurse #2 stated she neglected to care plan for Resident #81 for dialysis at the time of his annual assessment. She stated there had been a lot of turn over in the MDS office and a change in the computer system in April that could have resulted in the lack of care planning.</p> <p>In interview on 7/24/14 at 10:25 AM, the administrator stated it was her expectation MDS #2 Nurse accurately care plan any resident dialysis needs.</p>	F 279			

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F 280 F 280 SS=D	Continued From page 28 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to update the care plan for 1 of 2 sampled residents who had a fall (Resident # 34). Findings included: Resident # 34 was admitted into the facility on 2/5/2014 with medical diagnoses that included Hypertension, and Chronic Obstruction Pulmonary disease. The quarterly minimum data set (MDS) completed on 5/17/2014 indicated	F 280 F 280	F280 It is the policy and normal practice of this facility to develop a comprehensive care plan within 7 days after the completion of the comprehensive assessment and to periodically review, revise and update the care plan after each assessment. Affected Residents * The care plan of Resident #34 has been	8/27/14	

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F 280	<p>Continued From page 29</p> <p>Resident #34 had problems with short and long-term memory. Decision-making was indicated as severely impaired. The assessment further indicated the resident was independent and did not require assistance with bed mobility, transfer and locomotion.</p> <p>The care plan dated 3/16/2014 for Resident #34 revealed the resident was at risk for falls. Listed as a goal for risk for falls in part read "Resident will not sustain a fall through next review." Interventions included: "Transfer with assistance, assess need for low bed, monitor for unsafe maneuvers, provide appropriate safety teaching, and keep floor free of clutter." Further review of the care plan revealed the care plan was not updated during the last quarterly review dated 5/17/2014 and Resident's fall of 7/21/2014.</p> <p>Nurse's note dated 7/21/2014 documented "Resident observed sitting on the floor, called to room, no injuries noted."</p> <p>On 7/23/2014 at 9:00 AM, Resident # 34 was observed sitting on the chair in her room. A walker was observed next to the resident. The resident was not observed in any discomfort and no injuries were noted.</p> <p>Interview on 7/23/2014 at 3:00 PM, the MDS nurse stated it was her responsibility to update the residents' care plans at the facility. The MDS nurse stated she receives information in the morning stand up meetings about the residents and updates the care plan. She stated Resident #34's quarterly assessment was completed on 5/17/2014 but she forgot to update the care plan. She further added she was aware Resident #34 had a fall on 7/21/2014 but she forgot to update</p>	F 280	<p>reviewed, revised and updated by the Care Plan Team to indicate the fall on 7/21/14. The next quarterly review for this resident was 8/17/14 and the care plan has been reviewed and updated based on the quarterly assessment.</p> <p>Other Residents:</p> <ul style="list-style-type: none"> * The Incident Log has been reviewed for the past three months (5/14 - 7/14). The care plans of any resident who has had a fall in the past three months have been reviewed to ensure any falls are indicated on their care plan. All fall care plans were up to date and accurate. * The MDS Assessment schedule has been reviewed (5/14 - 7/14) to ensure there are no other missed care plan updates. All care plan reviews were up to date. <p>Systemic Changes:</p> <ul style="list-style-type: none"> * Care Plans have been moved from a separate binder and are now being placed in each individual resident's chart. * Fall Care Plans will continue to be updated as incidents occur. * Fall Care Plans will continue to be reviewed at the weekly Incident/Accident meeting. * The MDS Coordinator received a refresher in-service on 7/31/14 from the Nurse Consultant, RN, RAC (Resident Assessment Certification) regarding the importance of care plan review in accordance with the assessment schedule. 		

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F 280	Continued From page 30 the care plan with the new interventions, which included the use of a walker at all times while walking. Interview on 7/23/2014 at 3:45 PM, the Director of Nursing stated it was her expectation for the care plan to be updated to reflect the resident current status and condition. She added Resident #34's care plan should have been updated to reflect the walker which was a new intervention after the resident fell on 7/21/2014.	F 280	Quality Assurance: * The DON and/or designee will monitor the Incident Log to ensure any incidents are indicated on the care plan. * The DON and/or designee will review the MDS Assessment schedule to ensure care plans are being reviewed in accordance with the MDS Schedule. * Reviews will be done at least four times a week for four weeks; weekly for four weeks; monthly for four months and then ongoing quarterly, thereafter. * Results of the audit will be reported at the monthly Quality Assurance Committee meeting. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility	F 287		8/22/14	

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F 287	<p>Continued From page 31</p> <p>completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. <p>(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete and transmit an entry Minimum Data Set (MDS) within 14 days of readmission for 1 of 1 resident (Resident #81)</p>	F 287	<p>F287</p> <p>It is the policy and normal practice of this facility that, within 14 days after a facility</p>		

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F 287	<p>Continued From page 32 reviewed for readmission.</p> <p>Findings included:</p> <p>Resident #81 was admitted to the facility on 5/15/13 and readmitted on 6/23/14 with a diagnosis of end stage renal disease (ERSD).</p> <p>The most recent annual comprehensive MDS assessment was completed 3/30/14. This assessment indicated Resident #81 had severe cognitive impairment and required total assistance with his activities of daily living (ADLs) except for eating. The only other MDS noted on Resident #81 was a discharge MDS with return anticipated dated 6/14/14.</p> <p>In an interview on 7/22/14 at 5:00 PM, the Director of Nursing (DON) and the administrator stated that the MDS nurses were responsible for accuracy and submission timely Minimum Data Set's.</p> <p>In an interview on 7/23/14 at 10:30 AM, the MDS Nurse #2 stated she neglected to complete an entry MDS when Resident #81 returned from the hospital on 6/23/14. She stated she completed the entry MDS on 7/22/14 but offered no explanation as to why it was not completed with in the 14 day window. MDS Nurse #1 stated she had recently started at the facility and had not identified late MDS completion and submission as a concern.</p>	F 287	<p>completes a resident's assessment, to electronically transmit encoded, accurate and complete MDS data to the CMS System that includes the following: Annual assessment; significant change in status assessment; significant correction of prior full assessment; significant correction of prior quarterly assessment; quarterly review; a subset of items upon a resident's transfer; reentry, discharge, and death and background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.</p> <p>Affected Residents:</p> <p>* Transmission of entry MDS for Resident #81 was completed on 07/24/14.</p> <p>Other Residents:</p> <p>* The MDS Coordinator audited the MDS schedule on 7/25/14 to ensure that all other required MDS assessments were transmitted timely.</p> <p>Systemic Changes:</p> <p>* The Director of Nursing conducted refresher training with MDS Nurses on 7/25/14 regarding the RAI regulations on the schedule for transmitting MDS assessments.</p> <p>* The RN MDS coordinator will continue to ensure required MDS assessments have been transmitted timely utilizing the current MDS calendar.</p>		

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F 287	Continued From page 33	F 287	Quality Assurance: * The DoN and/or designee will systematically audit MDS Assessments that are to be transmitted every week to ensure timeliness of transmissions. This will be done weekly for one month; monthly for four months and then quarterly, thereafter. * Results of the audit will be reported at the monthly Quality Assurance Committee (QAA) meeting. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide follow up for a resident with a right hip fracture, failed to evaluate the need for continued treatment, failed to provide Physical Therapy advised turning, positioning and care training to staff providing care to the resident, failed to stop providing care, including wound care when the resident	F 309	F309 It is the policy and normal practice of this facility to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in	8/27/14	

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F 309	<p>Continued From page 34</p> <p>complained of pain for 1 of 2 residents (Resident #20). The facility also failed to adequately assess a dialysis resident for 1 of 1 sampled resident on dialysis (Resident #81). The immediate jeopardy began on 4/4/14 when the resident (Resident #20) with a right hip fracture was readmitted to the facility. The administrator was notified of the immediate jeopardy on 7/30/14 at 11:34 am. The immediate jeopardy was removed on 7/31/14 at 5:00 pm when the facility provided and implemented an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action. Example #2 is at a scope and severity of D.</p> <p>Findings included:</p> <p>1. Resident #20 was readmitted to the facility on 4/4/14 with medical diagnoses including displaced femoral neck fracture (right hip fracture), osteopenia and osteoarthritis. The significant change Minimum Data Set (MDS) assessment dated 4/7/14 indicated Resident #20's mental status was severely impaired. "Other fracture" and hospice care was listed as received during the review period. The MDS assessment also documented the resident was totally dependent for bed mobility with two persons plus assistance. The MDS assessment indicated the resident received a scheduled pain medication regimen with no complaints of pain during the review period. Further review of the medical record did not reveal a care plan for a hip fracture. The care plan updated 4/17/14 documented the resident problem was pain. The</p>	F 309	<p>accordance with the comprehensive assessment and plan of care.</p> <p>Affected Residents:</p> <ul style="list-style-type: none"> * An orthopedic appointment, with an orthopedic physician assistant (PAC), for Resident #20 was conducted on 07/29/14. * A hip fracture care plan was developed and initiated for this resident on 7/25/14 by the Care Plan Coordinator. * All nursing staff, including hospice were in-serviced by the SDC regarding resident #20's hip fracture and the safety precautions related to turning and repositioning that are to be observed beginning on 07/28/14. Hospice staff was in-serviced again on 07/31/14 by the hospice director. * All staff members caring for this resident have been made aware of the interventions contained in the care plan by the Director of Nursing. * The Care Guide in the resident's room was updated on 07/30/14 to include that if the resident is exhibiting any signs/symptoms of pain, staff is to notify the Charge Nurse so that appropriate pain interventions can be initiated. * Resident #81's plan of care was reviewed and revised by the Care Plan Coordinator on 7/22/2014 to address dialysis needs. * The care guide of Resident #81 was reviewed and revised by the Care Plan Coordinator on 07/22/2014 and now indicates dialysis interventions for this resident. * Beginning 7/22/2014, all staff was 		

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F 309	<p>Continued From page 35</p> <p>goal stated for the problem was the resident pain will be relieved within one hour of intervention through next review. Interventions for the problem in part were pain medication as ordered, check positioning when complaining of pain, notify MD (medical doctor) if pain medication ineffective, offer pain medication prior to potentially pain-inducing procedures such as physical therapy, wound care. Review of the hospice plan of care did not reveal a plan for a hip fracture or pain.</p> <p>Review of the hospital discharge summary dated 4/4/14 revealed Resident #20 had a displaced femoral neck fracture and was not a surgical candidate.</p> <p>Review of a nurses note dated 4/4/14 at 2:55 pm in part read "pt yelling out loud during pericare, monitoring in progress."</p> <p>Review of a nurse's note dated 4/4/14 at 10:30 pm, in part read "Yells out when turned and repositioned and when getting personal care. "</p> <p>Review of a nurse's note dated 4/5/14 at 06:45am in part read "Yells out upon touch and movement screams when care is given."</p> <p>Review of a nurse's note dated 4/5/14 at 11:00 (am or pm not indicated) in part read "yells out upon being touched, non-compliant at times when care given."</p> <p>Review of a nurse's note dated 4/7/14 at 04:30 am in part read "Resident continue to yell out when patient care being done. No complaints voiced."</p> <p>Review of the "Therapy Services Screening " dated 4/7/14 in part read "Patient (pt) is</p>	F 309	<p>in-serviced by the Staff Development Coordinator on the care of this resident related to dialysis needs.</p> <p>Other Residents:</p> <p>* The DoN and clinical nurses began on 7/22/14 reviewing those residents not sampled and their medical records to determine if those residents received the necessary care and services to maintain well-being and assure that a full assessment has been completed in the past month.</p> <p>* The Unit director reviewed all other resident charts and the transportation schedule on 7/30/14 to ensure there were no other missed appointments. All appointments are scheduled.</p> <p>* DoN and Unit Director reviewed all charts of resident receiving hospice service to ensure a care plan is in place on 07/30/14. All resident receiving hospice services have an appropriate hospice care plan.</p> <p>* DoN and Unit Director reviewed all charts of resident receiving dialysis service to ensure a care plan is in place on 07/22/14. All resident receiving dialysis services have an appropriate dialysis care plan.</p> <p>Systemic Changes:</p> <p>* An in-service was provided by the SDC on 7/28/14 to licensed nurses, regarding visualization of pain signs and symptoms.</p> <p>* A 24hr. Report Sheet has been</p>		

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F 309	<p>Continued From page 36</p> <p>maximum (max) assist X2 with bed mobility. Pt needs to remain in bed with X 2 assist for all mobility to avoid compromise of RLE (right lower extremity) fx (fracture)."</p> <p>Review of the medical record revealed Resident #20 was scheduled for a follow up appointment with a local orthopaedic office on April 15, 2014 for re-evaluation of the right hip fracture.</p> <p>Review of the "Radiology Report" of the right hip for Resident #20 dated 2/20/14 in part read "Subcapital femoral neck fracture is suspected of undeterminate age." Review of the CT scan of the pelvis dated 3/3/14 in part read "Right femoral neck fracture. Marked degenerative change." Review of the "Radiology Report" of a right hip X-ray dated 7/24/14 in part read "There has been some displacement of the fracture fragments consistent with acute re-injury at the subcapital femoral neck with the largest distal fragment now appearing displaced laterally 1.0 centimeters (cm)."</p> <p>Review of a progress note from the local orthopaedic office dated 7/29/14 in part read " discussed care with Power of Attorney. Patient with increased pain. Fracture displaced. Recommend total hip arthroplasty (THA). Discussed with POA and wish to proceed. Request medical evaluation and schedule right THA."</p> <p>On 7/23/14 at 10:34 am prior to beginning wound care, the Wound Care Nurse stated the resident normally complained of pain when being turned and stated the resident may yell out. During the observation of wound care, Resident #20 yelled out in pain multiple times when the Wound Care</p>	F 309	<p>developed so that the Charge Nurse can make all staff providing care aware of the care needs of each resident. Communication to hospice will be via the Care Guide, hospice communication tool and by phone. On an ongoing basis, all nursing staff will be made aware of any updates to the care plans related to any pertinent clinical issues via the 24hr. Report Sheet and the Care Guide which is placed in each resident's room.</p> <p>* A revised transportation schedule tool sheet was implemented on 08/04/14 to assure that appointments are captured.</p> <p>* Chart of residents returning from the hospital are routinely reviewed after the morning meeting to ensure there are no missed appointments.</p> <p>* A new Appointment Sheet was revised on 07/15/14 for the nurses to better identify when residents are having appointments.</p> <p>* After completing a Therapy Screen on a resident who has been readmitted from the hospital, the therapist conducting the screen will notify the Care Plan Coordinator of the results of the screen if any additional interventions should be implemented.</p> <p>* The Interim Care Plan has been reviewed and revised by the ADoN on 07/30/14 to ensure that an interim care plan is in place that addresses any type of injury, fracture, etc. that is present upon admission, so that the appropriate care and treatment can be provided.</p> <p>* The care guide will be updated on admission and as needed by the Charge Nurse, who will also notify hospice of any</p>		

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F 309	<p>Continued From page 37</p> <p>Nurse alone attempted to turn her onto her left side with the use of a cloth pad for the dressing change. The Wound Care Nurse stopped and returned with NA #3. While the two staff members were turning Resident #20, the resident continued to yell out in pain. With the NA holding both hands on the resident's back, the Wound Care Nurse turned the resident to the left side with the use of the cloth pad and Resident #20 grabbed her right upper thigh and yelled "It hurt right there." The Wound Care Nurse continued with wound care treatment. Immediately following the wound care at 10:43 am, the Wound Care Nurse was interviewed. She stated Resident #20 always complained of severe joint pain.</p> <p>On 7/23/14 at 10:50 am during an interview, Nurse # 2 stated it was normal for Resident #20 to cry out in pain when she was turned and repositioned.</p> <p>In an interview on 7/23/14 at 11:35 am, the Hospice Case Manager stated she was not aware that the resident was having pain with turning and repositioning.</p> <p>In an interview on 7/23/14 at 2:25 pm, NA # 3 (has worked with Resident #20 7-3 Monday through Friday since her readmission on 4/4/14) stated it was normal for Resident #20 to complain of pain when she was being turned and repositioned. She stated the resident always complained of pain on the right hip right where they said she had a fracture before. She stated she had worked with the resident before on another hall before she went out to the hospital and was aware she had a fracture but she thought the fracture was healed. She stated when the resident was on the other hall she would get</p>	F 309	<p>issues.</p> <p>* On 07/22/2014 the MDS Coordinator was instructed by the DoN to ensure that all residents who receive dialysis have a dialysis care plan and care guide in place.</p> <p>Quality Assurance:</p> <p>* The DoN and/or designee will randomly audit 20% of resident charts on a monthly basis to ensure appropriate care and services are being provided based on resident assessments. The primary focus of chart reviews will include hospital readmissions and significant changes in condition. In addition, care plans and medical records will continue to be systematically audited during the various weekly interdisciplinary meetings to ensure they are up to date and appropriate. This will be done on an ongoing weekly basis.</p> <p>* Results of the audit will be reported monthly to the Quality Assurance Committee by the DoN and/or designee. Any instances of noncompliance will be analyzed to determine when such noncompliance occurred, why and how. Appropriate responses will be initiated up to and including employee discipline and training, as needed.</p>		

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F 309	<p>Continued From page 38</p> <p>up out of bed. She further stated since the Resident #20 has been admitted to the current hall she do not get out of bed because it hurts too bad for you to move her.</p> <p>During a phone interview on 7/23/14 at 4:15 pm, the Hospice Case Manager stated she was not aware that Resident #20 had a hip fracture. Later, after reviewing the resident's admission paperwork for Hospice services, she stated she the paperwork included a diagnosis of femoral neck fracture.</p> <p>On 7/23/14 at 4:35 pm during an interview, the Wound Care Nurse stated she was not aware Resident #20 still had a hip fracture. She stated she thought the fracture was healed. She further stated she was not aware of any recommendations by PT for safety precautions or instructions for two persons assist with bed mobility at all times for Resident #20.</p> <p>On 7/24/14 at 10:37 am during an interview, NA #3 stated she was not aware of any special precautions she should take when turning the resident. She further stated she always turned and repositioned the resident alone. NA#3 stated she did not tell the nurse about the resident complaining of pain to the right hip when turned and repositioned because everybody was aware.</p> <p>During an interview on 7/24/14 at 11:03 am, the Staff Development Coordinator (SDC)/Transportation Supervisor stated the transportation department was not aware of the appointment. She further stated she do not know how the appointment was missed. The SDC/Transportation Supervisor stated the appointment has been rescheduled for July 30,</p>	F 309			

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F 309	<p>Continued From page 39 2014.</p> <p>On 7/24/14 at 11:55 am during an interview, Nurse #2 stated she was not aware Resident #20 had a right hip fracture. She acknowledged she completed the resident's admission assessment on readmission to the facility on 4/4/14. She further stated she did not implement any safety precautions related to a hip fracture for the resident. Nurse #2 stated she did not contact the doctor in reference to any safety precautions for the hip fracture because she did not know the resident had a hip fracture. After reviewing the hospital discharge summary dated 4/4/14, Nurse # 2 stated she must have overlooked the diagnosis.</p> <p>On 7/24/14 at 1:45 pm during a phone interview, Hospice NA #1 (who worked with Resident #20 since she was admitted to hospice services on 4/7/14) stated Resident #20 complained of right hip pain when she turned and repositioned her. She further stated she asked Nurse #2 and the Wound Care Nurse why the resident hollered so bad when you repositioned her when she first started working with the resident in April 2014. She stated she did not inform the Hospice Nurse because she was told the resident always complained of joint pain. The Hospice NA #1 stated the resident would holler when her right foot was touched. She further stated she always took care of the resident by herself. She further stated the care she provided to the resident included bathing and turning and repositioning. She stated the resident always complained of pain when she repositioned her. The Hospice NA stated the resident has complained of pain since she started working with her in April 2014. She stated she was not aware the resident had a hip</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>fracture. She further stated she was not aware of any safety precautions that she should take when working with Resident #20.</p> <p>On 7/24/14 at 1:57 pm, the Certified Occupational Therapy Assistant (COTA) (who spoke on behalf of the Rehab Director ' s absence) stated she was unable to provide any written documentation of training to the staff related to the recommendations documented on the screening form dated 4/7/14. She further stated the Physical Therapist that completed the PT screening was no longer employed at the facility. The COTA stated the staff should do log rolling when turning Resident #20 with a right fracture to minimize the pain and discomfort to the resident.</p> <p>On 7/24/14 at 2:30 pm an attempt was made to interview Physician #1 at the local orthopaedic office (where Resident #20 was initially evaluated for right hip fracture). Physician #1 stated he was deferring all questions related to Resident #20 to be answered by his Physician Assistant Certified #1 (PA-C) that has been caring for the resident.</p> <p>During an interview on 7/24/14 at 2:50 pm, NA #5 (has worked with Resident #20 on 3-11 shift Monday through Friday since her readmission on 4/4/14) stated Resident #20 complained of pain in her right leg daily when turned and repositioned. She further stated she was not aware that the resident had a right hip fracture or of any special precautions to take when the resident was turned.</p> <p>On 7/24/14 at 3:04 pm in an interview, Nurse #1 (has worked with Resident #20 on 3-11 shift Monday through Friday since she was readmitted to the facility on 4/4/14) stated she was not aware that Resident #20 had a hip fracture. She further</p>	F 309			

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F 309	<p>Continued From page 41</p> <p>stated she was aware that the resident yelled and complained of pain when being turned. Nurse #1 stated she thought this was normal for the resident since when was readmitted to the facility on 4/4/14.</p> <p>On 7/24/14 at 4:35 pm during an interview, the MDS Nurse #1 acknowledged there was no care plan for Resident #20 related to the right hip fracture and hospice care. The MDS nurse further indicated the care plan should have been updated to include goals and interventions related to the hip fracture and hospice care. She further stated she was not aware the resident had a hip fracture.</p> <p>During an interview on 7/24/14 at 6:05 pm, the Director of Nursing (DON) stated it was her expectation for the hall nurse to complete an interim care plan upon the resident's admission or readmission to the facility. She further stated she expected the nurse to transfer the care plan information to the care guide for the NA's (Nursing Assistants) to have as a reference when providing care to the resident. The DON stated it was her expectation for the hall nurse to address the resident's complaint of pain with medication or any other intervention that may be appropriate. She further stated if the interventions were attempted and not effective, it was her expectation for the nurse to get on the phone and notify the physician immediately. She added she expected the staff to stop the procedure if a resident was complaining of pain until the pain was under control. She stated it was her expectation for the staff to ensure the resident made it to her scheduled appointment. She further stated she was not aware of what happened in Resident #20's case that resulted in</p>	F 309			

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F 309	<p>Continued From page 42</p> <p>the resident not going to her scheduled follow up appointment on April 15, 2014.</p> <p>On 7/29/14 at 4:07 pm in an interview, the Physician Assistant Certified #1(PA-C) for the local orthopaedic office stated it was his expectation for the facility to arrange for the resident to attend the scheduled follow up appointment on 4/15/14. The PA-C stated the plan for the follow up appointment that was scheduled for April 15, 2014 was to repeat the X-rays to see if there were any changes. The PA-C stated if the resident would have been seen at the earlier appointment date and changes were noted, treatment could have been initiated sooner. He stated failure to provide safety measures or protective handling for a resident with a hip fracture could result in increased pain to the resident or displacement of the fracture. He further explained safety measures would include supporting the affected extremity and log rolling.</p> <p>On 7/30/14 at 9:45 am during an interview, the orthopaedic PA-C #1 stated his evaluation of the patient and the most recent X-rays on 7/29/14 revealed Resident #20 was experiencing excruciating pain. He stated there has been a significant decline in the condition of the resident's right hip. PA-C #1 stated surgery was now recommended to help alleviate the pain even though the resident was a high risk surgical candidate.</p> <p>During a family interview on 7/30/14 at 2:25 pm, the Power of Attorney stated he was not aware the resident had missed her follow up appointment. He stated he wanted the bone doctor to keep a check on the resident's hip because she was having so much pain with it. He</p>	F 309			

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F 309	<p>Continued From page 43</p> <p>stated he has been in to visit the resident and has seen how much pain she was having especially when she was being moved by the staff.</p> <p>In a phone interview on 7/31/14 at 10:30 am, the attending physician stated it was his expectation for the facility to handle the resident with care. He further stated it was his expectation for the facility to notify him if the resident was experiencing still experiencing pain with the current medication regimen. The attending physician stated he would have ordered pain medication to be given before turning and repositioning or whatever was indicated at the time to make the resident comfortable. The attending physician stated he was not aware of the follow up appointment with the orthopaedic office that was scheduled for April 15, 2014. He stated it was his expectation for the facility to honor the wishes of the resident or Power of Attorney (POA) at all times.</p> <p>In an interview on 7/31/14 at 11:35 am, the Hospice Case Manager verified the hospice plan of care for Resident #20 did not address the right hip fracture or pain. She further stated she has not reviewed Resident #20's plan of care for any needed revisions or for validation with the facility's care plan.</p> <p>The facility provided the following Credible Allegation on July 31, 2014 at 5:00 pm.</p> <p>F309 It is the policy of this facility to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the</p>	F 309			

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F 309	Continued From page 44 comprehensive assessment and plan of care. Corrective Action for Identified Resident- <ul style="list-style-type: none"> · Prior to working a scheduled shift, nursing staff (all but 4 have been in-serviced), including hospice (100%), were in-serviced by SDC regarding Resident #20 ' s hip fracture and the safety precautions related to turning and repositioning that are to be observed beginning 07/28/14. Hospice staff (100%) was in-serviced again on 07/31/14 by the hospice director. · The orthopedic appointment was reset for this resident and resident was seen by the orthopedic physician on 7/29/2014. The orthopedic surgeon recommended hip arthroplasty pending consult with the attending physician, hospice and family. The attending physician will discuss this option with the family, however, several times in the past, the family has declined to have this surgery done. · A hip fracture care plan has been developed and initiated for this resident on 07/25/14 by Care Plan Coordinator. Prior to working a scheduled shift nursing staff will be made aware of the interventions contained in the care plan. · The Care Guide in the resident ' s room has been updated on 07/30/14 to include that if the resident is exhibiting any signs/symptoms of pain, staff is to notify the Charge Nurse so that appropriate pain interventions can be initiated. · A Nurse to Nurse report sheet has also been developed so that the Charge Nurse can make all staff providing care aware of the care needs of each resident. Communication to hospice will be via the Care Guide, hospice communication tool and by phone. · Charge nurse duties include the participation of assessment & MD notification of resident level of pain or other symptoms of hip issues. 	F 309			

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F 309	Continued From page 45 Id & Corrective Action of other residents having the potential to be affected- <ul style="list-style-type: none"> · All other resident charts and the transportation schedule have been reviewed to ensure there were no other missed appointments on 07/30/14 by unit director. There were 5 missed follow-up appointments. Missed appointments were immediately contacted and appointments scheduled. · All charts were reviewed of residents receiving hospice services to ensure a care plan is in place by DoN and unit director on 07/30/14. All residents receiving hospice services have an appropriate hospice care plan. · The Interim Care Plan has been reviewed and revised by the ADoN on 07/30/14 to ensure that an interim care plan is in place that addresses any type of injury, fracture, etc. that a resident is admitted to the facility with so that the appropriate care and treatment can be provided. Charge nurse and MDS updates care guide and notifies hospice. · In-services provided by the SDC beginning on 07/28/14 to licensed nurses included visualization of pain signs and symptoms. · All nursing staff will be made aware of any updates to the care plans related to any pertinent clinical issues via the Nurse to Nurse Report Sheet and the Care Guide which is placed in each resident ' s room. <p>Date of Completion: 7/31/2014</p> <p>On 7/31/2014 at 5:30 pm, verification of the credible allegation was evidenced by interviews of licensed nursing staff related to the monitoring and assessment of residents exhibiting signs and</p>	F 309			

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F 309	<p>Continued From page 46</p> <p>symptoms of pain. The licensed nurses verified the change related to the assessment of residents exhibiting pain and the notification to the physician as indicated. Verification of the credible allegation continued with interviews of licensed nurses regarding initiating and updating the resident ' s care plans with any change in their care needs. The licensed nurses verified the care plan would be updated immediately and the care guides would be updated so the NA ' s would be aware of the changes. The nurses also verified the use of the Nurse to Nurse report which has been implemented for the exchange of important information between the nursing staff. Verification of the credible allegation was also continued with interviews of the hospice staff related to the new communication form for the exchange of information between the facility and hospice related to any changes or concerns of the resident ' s condition.</p> <p>2. Resident #81 was admitted to the facility on 5/15/13 and readmitted on 6/23/14 with a diagnosis of end stage renal disease (ERSD). Dialysis was scheduled for Tuesdays, Thursdays and Saturdays per physician's orders</p> <p>The facility had no policy or procedure for the care and assessment of a dialysis resident or provided no evidence of education to licensed or unlicensed staff on how to manage care/complications for a dialysis resident.</p> <p>The annual Minimum Data Set (MDS) completed 3/30/14 indicated Resident #81 had severe cognitive impairment and required total assistance with his activities of daily living (ADLs) except for eating. There was no care plan for his dialysis shunt precautions, assessment,</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>complications or emergencies common in dialysis residents.</p> <p>A review of the medical record revealed the last dialysis communication form was completed on 7/15/14 and the last nursing note was completed on 7/12/14 on Resident #81. The dialysis communication form indicated that the dialysis staff were to obtain and pre and post weight and a post blood pressure on Resident #81. There was a place for dialysis staff to indicate any abnormal findings, treatments, medications or any new orders or changes that may have occurred during the dialysis treatment. There was no place on the form for facility staff to document any assessment or monitoring following Resident #81's return to the facility after his treatment.</p> <p>In an interview on 7/22/14 at 4:50 PM, nursing assistant (NA) #1 stated she was not educated on the care of a dialysis resident but stated she was a medic and knew the precautions necessary for a dialysis resident. NA #1 stated she was unaware of the facility 's expectation regarding the care of Resident #81 but the staff was instructed to follow what was on the resident status sheet located in each resident closet for specific care information. A review of Resident #81's status sheet made no mention of specific precautions or assessments for a dialysis resident.</p> <p>In an interview on 7/22/14 at 4:53 PM, Nurse #1 stated Resident #81 went to dialysis on first shift and returned on her shift. She stated the dialysis center was expected to send the dialysis communication form back with Resident #81 but they often did not. Nurse #1 stated she did not routinely follow up on the form but the clinic would</p>	F 309			

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F 309	<p>Continued From page 48</p> <p>call if there was a complication with Resident #81. When questioned regarding any dialysis specific care she completed for Resident #81 after a treatment, Nurse #1 stated the aides would lay Resident #81 down and offered him dinner.</p> <p>In an interview on 7/22/14 at 5:00 PM, the Director of Nursing (DON) stated that the floor nurses sent the dialysis communication form to dialysis with Resident #81 and the dialysis staff documented any clinical events like a drop in his blood pressure or infiltration of his shunt on the form so the facility staff could follow up with needed monitoring. The DON was unaware of the management, complications or emergencies regarding a dialysis resident. The DON stated that if there was a specific monitoring need after a dialysis treatment, the dialysis clinic called and reported it to the assigned nurse on the hall.</p> <p>In an observation on 7/22/14 at 5:10 PM, Resident #81 was observed in bed. He had just returned from dialysis. There was an observed dry dressing to his left lower arm. He was easily aroused and appeared in no distress.</p> <p>In an interview on 7/23/14 at 8:40 AM, NA #2 stated she had not received training from the facility about the care of a dialysis shunt or the care a dialysis resident. NA #2 stated she was told to refer to the resident status sheet to see how to care for Resident #81. NA #2 reviewed Resident #81 ' s resident status sheet in his closet and stated there was nothing indicating Resident #81 was a dialysis resident or that he had a dialysis shunt in his arm. NA #2 stated resident #81 would not be able to communicate that information based on his cognition. In an observation at this time, Resident #81 was sitting</p>	F 309			

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F 309	Continued From page 49 up in bed with a dry dressing observed to his left lower forearm. He was pleasantly confused and unable to have a meaningful conversation. In an interview on 7/23/14 at 9:00 AM, NA #3 stated she unaware how to care for dialysis shunt and was unaware how to manage emergencies and complications. In an interview on 7/24/14 at 9:00, Nurse #2 stated resident #81 went to dialysis on her shift and she made sure the dialysis communication form went with him in his lunch bag for each treatment. Nurse #2 stated he returned on second shift and the second shift nurse would ensure the form returned with him. Nurse # 2 stated she applied lidocaine to his shunt before his treatments and palpated for a thrill to his shunt prior to the medication application. In an interview on 7/24/14 at 10:25 AM, the administrator stated her expectation of clinical staff to assess any dialysis access site and monitoring for bleeding at the dialysis site after a dialysis treatment but she was unaware of the management of potential emergencies or complications of a dialysis resident.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		8/12/14	

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F 318	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide restorative services to prevent further decline in a resident (Resident #81) with a right hand contracture for 1 of 2 residents reviewed for limited range of motion (ROM). Findings included:</p> <p>Resident #100 was admitted to the facility 01/06/12 with diagnoses of cerebral vascular accident (CVA). The quarterly Minimum Data Set (MDS) dated 5/30/14 indicated Resident #100 was cognitively intact with impairment in ROM in his upper and lower extremity on one side and received restorative passive ROM 6 times per week.</p> <p>A review of the medical record did not include a the care plan addressing the Resident #100's ROM limitations or any physician orders for restorative services. The only baseline information available in the medical record regarding the right upper extremity (RUE) was dated 01/03/12 which indicated Resident #100 had increased tone to RUE and he would benefit from a long term progressive rehabilitation.</p> <p>In an observation on 07/21/14 at 2:00PM, Resident #100 was noted to have a right hand contracture. He was able to use his left open to open his right hand but stated it was painful and "tight". Resident #100 stated he was not receiving any services for his right hand contracture but he had received restorative services in the past. He stated he could not tell if the contracture had worsened since his admission to the facility.</p>	F 318	<p>F318</p> <p>It is the policy and normal practice of this facility to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Affected Residents:</p> <ul style="list-style-type: none"> * Restorative Nursing Staff is now providing Passive Range of Motion (PROM) to the right hand of Resident #100. * Resident #100 has a care plan in place addressing the preventative measures for right hand contracture and the restorative services being provided. <p>Other Residents:</p> <ul style="list-style-type: none"> * All recent therapy screens have been reviewed to identify any other residents who are at risk for developing contractures to ensure appropriate ROM services are being provided. * All residents receiving ROM/restorative services have a care plan in place addressing ROM/restorative needs. <p>Systemic Changes:</p> <ul style="list-style-type: none"> * Therapy will continue to screen all residents based on the MDS Assessment 		

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F 318	<p>Continued From page 51</p> <p>In an interview on 07/22/14 at 3:25 PM, the rehabilitation director stated Resident #100 was not picked up for occupational services or referred to restorative services based on his last screening completed on 04/29/14 indicating no change in his functional status. MDS Nurse #2 initiated restorative active ROM for Resident #100's right hand contracture in April then changed it to passive ROM in May and stopped all ROM in June.</p> <p>On 07/23/14 at 8:30AM, the Director of Nursing (DON) stated she relied on therapy services to identify any contracture management needs and she thought restorative services were currently being provided for passive ROM to Resident #100's right hand contracture.</p> <p>In an interview on 07/23/14 at 10:30 AM, MDS Nurse #2 stated she did not recall initiating or discontinuing restorative services for Resident #100 but she verified she coded his quarterly 05/30/14 MDS as receiving passive ROM.</p> <p>In an interview on 07/23/14 at 10:30 AM, MDS Nurse #1 stated if Resident #100 required ROM for a known right hand contracture, there should have been a therapy evaluation with written orders and a plan of care.</p> <p>In an interview on 07/23/14 at 9:37 AM, the restorative aide stated she performed passive ROM to Resident #100's right hand up until 06/03/14 when the MDS Nurse #2 stopped the services. She stated she did not know why services were stopped but Resident #100 had questioned her about why he was not longer on her case load and she instructed him to use his</p>	F 318	<p>schedule.</p> <ul style="list-style-type: none"> * A Restorative Nursing meeting is being held weekly to discuss all residents receiving ROM/restorative nursing services to ensure appropriate restorative nursing services are being provided. * Restorative Care plans are updated as needed to reflect ROM/restorative services. * Nurse Consultant in-serviced restorative nurse and restorative aides on 8/12/14 regarding expectations related to the facility's restorative nursing program policies and procedures. <p>Quality Assurance:</p> <ul style="list-style-type: none"> * The DoN and/or designee will audit the routine therapy screens to ensure any residents exhibiting decline in ROM is receiving appropriate restorative services. This will be done weekly for four weeks; monthly for four months and then ongoing quarterly thereafter. * Results of the audit will be reported by the DoN at the monthly Quality Assurance Committee meeting. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken. 		

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F 318	Continued From page 52 other hand to open his hand and stretch his fingers. The restorative aide could not verify if there was a decline in ROM to Resident #100's his right hand contracture since she was not longer working with him. In interview on 07/24/14 at 10:25 AM, the administrator stated her expectation would be for any resident with a contracture to receive services to maintain present level of function and prevent ROM decline.	F 318			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		8/27/14	

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F 431	<p>Continued From page 53</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to remove expired medications from 2 of 8 medication carts (A Hall cart #1, C Hall cart #1).</p> <p>The findings included:</p> <p>1) An observation of the A Hall medication cart #1 on 7/22/14 at 4:20 PM revealed the following medications stored on the cart were expired:</p> <p>Expired Medications #1, #2, #3:</p> <p>Medication #1: An expired vial of Novalin-R insulin labeled for resident #69 was stored on the medication cart. The insulin was unopened in the package as dispensed by the pharmacy with a dispensed on date of 3/04/14.</p> <p>Medication #2: An expired vial of Novalin-R insulin labeled for resident #61 was stored on the medication cart. The insulin was unopened in the package as dispensed by the pharmacy with a dispensed on date of 6/02/14.</p> <p>Medication #3: An expired vial of Novalin-R insulin labeled for</p>	F 431	<p>F431</p> <p>It is the policy and normal practice of this facility to label drugs and biologicals in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable.</p> <p>Affected Areas:</p> <p>* The unopened expired insulin vials were immediately removed from the A Hall Cart #1 and C Hall Cart #1 and returned to pharmacy.</p> <p>Other Areas:</p> <p>* The other six medication carts were checked for dates past the manufacturers recommended use by date. No expired items were found in any of the other carts.</p> <p>Systemic Changes:</p> <p>* The Staff Development Coordinator and</p>		

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F 431	<p>Continued From page 54</p> <p>resident #61 was stored on the medication cart. The insulin was unopened in the package as dispensed by the pharmacy with a dispensed on date of 1/04/14. The manufacturer's expiration date stamped on this vial was 5/14, consequently this vial was also expired by the manufacturer's expiration date.</p> <p>The manufacturer's product information indicated, " unopened vials of Novalin-R insulin are to be refrigerated prior to opening " and " if not refrigerated, vials may be stored for use within 28 days."</p> <p>An interview was conducted with the nurse assigned to the A Hall medication cart on 7/22/14 at 4:30 PM. During the interview Nurse #3 stated that it was her understanding that unopened vials of Novalin-R insulin were to be stored on the medication cart. She further stated that she thought unopened insulin stored unrefrigerated on the medication cart would not expire until 28 days after the vial was opened. She promptly removed the expired insulin from the medication cart.</p> <p>2) An observation of the C Hall medication cart #1 on 7/22/14 at 4:30 PM revealed the following medication stored on the cart was expired:</p> <p>Expired medication #4: An expired vial of Novalin-R insulin labeled for use by resident #27 was stored on the medication cart. The insulin was unopened in the package as dispensed by the pharmacy with a dispensed on date of 6/13/14.</p> <p>The manufacturer's product information indicated, " unopened vials of Novalin-R insulin are to be</p>	F 431	<p>DoN beginning 08/07/2014 conducted refresher training with Nurses regarding discarding procedures for expired items/products.</p> <p>* Night shift will continue to check the carts and storage areas for expiration dates on a daily basis.</p> <p>* The QA nurse and/or designee will also check carts and storage areas weekly for expiration dates.</p> <p>* All unopened insulin vials are now stored in the refrigerator and will continue to be checked on a weekly basis for an expiration date.</p> <p>* Pharmacy will continue to check the medication carts and storage areas on a monthly basis.</p> <p>Quality Assurance:</p> <p>* The QA nurse and pharmacy consultant will continue to check the medication carts and storage areas on a monthly basis and report findings to the DoN.</p> <p>* DoN/or designee will report findings monthly to the Quality Assurance Committee (QAA) for four months to monitor effectiveness of the plan. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.</p>		

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F 431	Continued From page 55 refrigerated prior to opening " and " if not refrigerated, vials may be stored for use within 28 days." An interview was conducted with the nurse assigned to the C Hall medication cart on 7/22/14 at 4:38 PM. During the interview Nurse #1 stated insulin should be kept in the refrigerator until it is opened. She promptly removed the expired insulin from the medication cart. An interview was conducted with the facility pharmacist on 7/22/14 at 5:05 PM. During the interview she stated the facility policy indicated that Novalin-R insulin be placed in the refrigerator when it comes in from the pharmacy. She further stated that Novalin-R insulin can be kept for 28 days unopened on the cart. She stated the insulin dispensed on 6/13/14 which was stored in the unrefrigerated medication cart would be expired. An interview was conducted with the facility administrator and the DON on 7/22/14 at 5:10 PM. During the interview both the administrator and the DON stated that it was the facility policy and their expectation that unopened Novalin-R insulin be stored in the refrigerator until use. They both agreed that the four vials of insulin which had been stored incorrectly on the medication cart were expired and should be disposed of.	F 431			
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 497		8/22/14	

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F 497	<p>Continued From page 56</p> <p>education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 1 of 1 nursing assistant (NA) 12 hours of in-service training annually (NA #4). Findings included:</p> <p>A review of the employee information report revealed NA #4 was hired on 6/18/13. The NA in-service record did not reflect NA #4 had completed 12 hours of in-service training on 7/29/14.</p> <p>On 7/29/14 at 4:41 pm, the staff development coordinator stated she did not have in-service records that confirmed the amount of training hours NA #4 had received.</p> <p>On 7/29/14 at 4:45 pm, the administrator stated she expected 12 hours of annual in-service to have been completed for NA #4.</p>	F 497	<p>F497</p> <p>It is the policy and practice of this facility to provide regular in-service education. The in-service training provided is sufficient to ensure continuing competence of nurse aides, and is no less than 12 hours per year.</p> <p>Affected Areas:</p> <p>* Review of in-service attendance records revealed that C.N.A. #4 is actually on track for achieving the required 12-hours of annual in-service training. The individual record sheet has been updated accordingly.</p> <p>C.N.A. #4's in-service records were reviewed and revealed the following:</p> <p>* C.N.A. #4's hire date was 6/18/2013 * C.N.A. #4 received 5.25 hours of in-service during orientation on such topics</p>		

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F 497	Continued From page 57	F 497	<p>as resident rights, blood borne pathogens, infection control, etc.</p> <p>* The Inservice Calendar from 8/8/2013-12/30/2013 was reviewed and approximate times of each inservice was added to the Master Inservice Sheet</p> <p>* Review of the Attendance Sheets revealed that C.N.A. #4 had at least 2 additional hours of inservice from 8/8/13-12/30/13 which equals 7.25 hours from 6/18/13-12/30/13.</p> <p>* The Inservices conducted from 2/21/14-5/26/14 were also reviewed and revealed that C.N.A. #4 attended an additional 3 hours and 55 minutes of inservice to equal 11 hours and 20 minutes of inservice between 6/18/13 and 5/26/14.</p> <p>* An additional one hour of inservice was provided to C.N.A. #4 between 7/30/14 and 8/20/14 to equal 12+ hours (12 hours and 20 minutes)</p> <p>* The inservice attendance records of C.N.A. #4 are now up to date and current and are being tracked after each inservice to ensure the required number of inservice hours are met.</p> <p>Other Areas:</p> <p>* All in-service attendance records were reviewed to ensure other C.N.A.'s in-service records accurately reflected their completed hours to ensure achieving their required 12-hours of annual in-service training.</p>		

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F 497	Continued From page 58	F 497	<p>Systemic Changes:</p> <ul style="list-style-type: none"> * The duration of an in-service is now being recorded on the attendance sheets and training records. * The form utilized to track each staff member's in-service attendance/hours on an individual basis was revised. * The DoN provided on 7/22/14 refresher training to the nursing clerk and SDC regarding policy and procedures regarding in-service attendance sheets and time records. * The SDC is reviewing these records on a monthly basis to monitor completion of at least 12-hours of continuing education per year. In the event someone does not complete their required hours by the end of each calendar year, they will not be scheduled to work until their remaining hours are completed. * The inservice attendance of all staff is now being tracked following each inservice to ensure the required number of inservice hours are being met. * Inservice hours for all staff are being tracked on a yearly basis from January through December. * The SDC will notify any staff member who is behind in required inservice hours so that additional inservices can be attended. * The SDC will notify the Administrator and DON for further follow up of any staff member who is behind on the required number of inservice hours. <p>Quality Assurance:</p>		

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F 497	Continued From page 59	F 497	<p>* The DoN and/or designee will audit in-service records monthly to ensure that in-service records are complete and the duration of the in-service is indicated for all in-services. This will be done on an ongoing basis.</p> <p>*Results of the audit will be reported quarterly at the monthly Quality Assurance Committee meeting. Any instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.</p>		