STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 08/07/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to offer/provide showers per its policy of two showers weekly for 1 of 2 sampled residents (Resident #5) whose family expressed the desire for the policy to be followed. Findings included: Resident #2 was admitted to the facility on 08/16/12. Her documented diagnoses included diabetes, dementia, anxiety, and depression. Review of the facility's shower schedule documented Resident #5 was scheduled to receive showers weekly on Wednesdays and Saturdays during second shift. Resident #5's bath/shower report documented that in May 2015 she received 1 of 9 possible showers based on the facility's shower schedule. A 06/02/15 quarterly minimum data set (MDS) documented Resident #5 had severe cognitive impairment, was dependent on a staff member for bathing, was always incontinent of bowel and bladder, and did not reject or resist care.	F 242	F242 Right to Choose Resident # 5 was given a shower by the assigned CNA on 8/9/15 with documentation in the clinical record. A resident choice questionnaire was completed by Social Workers with 100% of all alert and oriented residents regarding preferences in care to include preferences regarding baths or showers by the Social Workers. The Social Workers contacted the responsible party of any resident unable to complete the resident choice questionnaire to include resident # 5 by 8/29/15 to determine if they had any preferences regarding resident care to include preference regarding baths or showers. The Minimum Data Set (MDS) Nurses immediately addressed all identified areas of concerns from the resident choice questionnaire by updating the resident care plan and care guide to reflect the residents¿ preference completed by 8/29/15. The Social Workers reviewed the federal resident rights with all alert and oriented residents and a copy of the	9/4/15

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

Electronically Signed | 08/28/2015

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F 242	Continued From page 1 Resident #5's bath/shower report documented, based on the facility's shower schedule, she received 2 of 8 possible showers in June 2015, 5 of 9 possible showers in July 2015, and 0 of 2 possible showers in August 2015. At 12:18 PM on 08/04/15 a family member stated that Resident #5 was not getting the two showers weekly for which she was scheduled. The family member reported in discussions with the nursing assistants (NAs) assigned to care for the resident she expressed her desire for the resident to receive the two showers weekly from a cleanliness and health standpoint. At 3:15 PM on 08/07/15 NA #6 stated Resident #5 enjoyed her showers, and had problems with an itching scalp when she did not get regular showers. She reported that the resident was not always getting two showers a week. She explained several factors contributed to this lack of showers including heavy resident assignment load, the heat on the resident's hall which made showers very uncomfortable by increasing humidity and perspiration, and cooperation from other shifts. She commented she heard family members complaining about residents not getting enough showers. At 3:32 PM on 08/07/15 NA #7 stated Resident #5 "loved her showers", and never refused them. However, she reported the NAs were having a difficult time providing two showers weekly because there were so many extensive and total care residents on the hall who required a lot of time to care for. At 5:30 PM on 08/07/15 the director of nursing (DON) stated residents in the facility were	F 242	federal resident¿s rights was given to the residents completed on 8/28/15. A copy of the federal resident¿s rights was sent to the responsible party by the Social Workers on 8/27/15 for all other residents to include resident #5. A 100% in-service was initiated by Assistant Director of Nursing (ADON) with all facility staff to include NA # 6, NA #7, all Certified Nursing Assistants (CNAs), all licensed nurses, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping, receptionist and social workers staff regarding residents rights and right to make decisions, to include making choices regarding preference for bath or shower to be completed by 9/4/15. All newly hired staff will be in-serviced by the staff development coordinator (SDC) during orientation regarding residents rights and right to make decisions, to include making choices regarding preference for bath or shower. When a resident is admitted to the facility the resident or responsible party will be informed by the Social Worker of their right to make choices regarding activities, schedules, and health care consistent with his or her interests, assessments, and plan of care, to include preference for bath or shower. A choice questionnaire will also be presented to the resident and or responsible party regarding preferences in care. The Social Worker will forward a copy of the resident choice questionnaire to the MDS nurse and the MDS nurses will immediately update the resident preferences on the resident care	

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F 242	Continued From page 2 supposed to be offered showers twice weekly. She reported a shower team had been disbanded because it was ineffective. She commented in-servicing was completed during which NAs were instructed to provide full bed baths if showers could not be given. The DON also remarked the hall nurses were supposed to remind the NAs of the residents that were due showers daily. According to the DON, she was not made aware there were current problems with being able to provide the two showers weekly to residents.	F 242	guide and resident care plan. If during the facility stay the resident indicates a change in preferences to include preference for bath or shower the residents care plan and care guide will be updated immediately by the MDS Nurse. A resident choice questionnaire will be completed with 10% of all alert and oriented residents by the MDS Nurses weekly x 8 weeks then monthly x 2 months to ensure residents preferences are being honored and for any changes in preferences to include preference for bath or shower utilizing a QI Residents¿ Right to Choose Tool. The MDS nurses will immediately address any identified areas of concern and update the resident care plan for any changes. Resident care observations will be completed by the Nurse Supervisors, Director of Nursing (DON), ADON, and SDC for 10% of the residents, including resident # 5, on all shifts to include nights and weekends to observe license nurses and CNAs to ensure residents¿, including resident #5, preferences are being honored to include preferences regarding bath or shower utilizing a Resident Care Audit Tool 3x per week x 4 weeks, weekly x 4 weeks, then monthly x 2 months. Retraining will be conducted by the Nurse Supervisors, DON, ADON, and SDC during the audit for any identified areas of concern The Administrator or DON	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe	F 257		9/4/15

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F 257	Continued From page 3 temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and record review the facility failed to provide timely in-room relief from temperatures above 81 degrees Fahrenheit at 1 of 4 nursing stations (Station #1). Findings included: At 3:48 PM on 08/04/15 a family member stated they were visiting with a resident on the 100 hall, and were concerned because of the extremely uncomfortable temperatures on the hall during a month and a half period. They reported the resident was very uncomfortable, perspired heavily, and complained about the heat to staff during this time period. The family commented nothing was done by the facility to relieve the heat in resident rooms until the last week before the air conditioning system was repaired. According to the family, the facility placed a fan at the end of the hall which only stirred up hot air, and did not provide any relief to residents confined to their rooms. At 10:20 AM on 08/04/15 a family member stated their loved one, a resident on the 100 hall for a short period of time, was moved to the 100 hall about the third week in July 2015. The family reported by the afternoon of the first day on the 100 hall they found the resident "dripping wet" from the heat. They explained the resident was covered in perspiration, and the resident's sheets were damp from the heat. When the family questioned the maintenance manager, he stated	F 257	The facility will continue to provide effective maintenance service to assure environmental temperatures remain between 71 ¿ 81 degrees. The air condition unit on station one was repaired 7/28/15. The maintenance Director recorded temperatures on each in each hall way and in 3 rooms on each hall way using a Temperature Audit Log on 8/11/15. No issues were identified. The Maintenance Director and Maintenance Assistant were re-educated on 8/11/15 related to maintaining temperatures within the facility between 71 ¿ 81 degrees. The Maintenance Director and Maintenance Assistant will audit temperatures in each hall way and in 3 rooms on each hall way using a Temperature Audit Log 3 x weekly x 4 weeks, weekly x 4 weeks, monthly x 2 months to assure required temperatures are maintained. Audit Tools will be reviewed by the Administrator weekly x 8 weeks and monthly x 2 months. Weekly audit results will be reviewed monthly x 3 by the Executive QI Committee to determine if a revision of the Plan of Correction is needed.	

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F 257	Continued From page 4	F 257		

there had been problems with the air conditioning on the hall for about six weeks. The family commented the facility did not offer to provide any fans in the resident's room, but they (the family) brought two small fans from home. The family stated there were other rooms vacant in the facility, and they did not understand why their loved one was even placed in the room on the 100 hall. They commented the resident had a history of breathing problems and pneumonia. Eventually, through their persistence, they reported the resident was moved to another hall.

At 12:18 PM on 08/04/15 a family member stated their loved one was also a resident on the 100 hall, and was frequently found wet from perspiration. They reported on one of the hottest days, when it was 107 degrees Fahrenheit outside with the heat index, they found a puddle of water under the resident's back. The family commented the heat problem went on for at least six weeks. They stated the maintenance manager was very frustrated, and remarked that there had been a lot of unsuccessful repairs to the air conditioning system which serviced the 100 hall. According to the family, the lack of air conditioning started in early June, and it was not until 07/23/15 that the facility finally purchased a window air conditioner for the resident's room.

At 10:00 AM on 08/05/15 Nurse #6, who worked on the 100/300 halls (Nurse Station #1), stated the air conditioning did not work right on the 100 hall for over a month. She reported the thermometer on the 100 hall registered as hot as 82 degrees Fahrenheit. She commented the facility provided a big fan placed at the end of the hall, and about a week before the air was fixed, the facility purchased five or six window air

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F 257	Continued From page 5	F 257		

conditioners.

At 4:40 PM on 08/06/15 a nursing assistant, (NA) #2, who worked on the 100/300 halls (Nurse Station #1), stated the air conditioning was out on the 100 hall from the first of June to nearly the end of July. She reported residents were perspiring heavily, and residents and family members were complaining. She commented some type of big fan was placed at the end of the 100 hall, but it was not very effective in cooling individual resident rooms. According to the NA, some families brought in small fans from home.

At 4:45 PM on 08/06/15 NA #3, who worked on the 100/300 halls (Nurse Station #1), stated the air conditioning on the 100 hall was out for over a month. She reported residents were perspiring heavily and complaining. She commented it got so hot that she felt light headed herself so she imagined the residents were uncomfortable also.

At 9:07 AM on 08/07/15 NA #4, who worked on the 100/300 halls (Nurse Station #1), stated residents and family members complained for over a month about the heat on the 100 hall. She reported residents were perspiring heavily, but she was not aware of any respiratory problems. However, she commented she thought several residents were moved due to the heat. According to the NA, the facility provided a large fan at the end of the hall, some families brought fans from home, and toward the end of July 2015 the facility purchased some window air conditioners. She commented she thought the issues with the heat began in early June 2015.

At 9:13 AM on 08/07/15 Nurse #3, who worked on the 100/300 halls (Nurse Station #1), stated it

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F 257	Continued From page 6	F 257		

got so hot over one weekend that several residents were moved because they could no longer tolerate the heat on the 100 hall. She reported the large fan at the end of the 100 hall did not help cool individual resident rooms, but some family members brought in fans to place in their loved ones' rooms.

At 9:18 AM on 08/07/15 Nurse #7, a weekend supervisor, stated she was involved in moving two residents off the 100 hall over a weekend because the heat made the residents very uncomfortable.

At 10:36 AM on 08/07/15 the maintenance manager (MM) stated he was first made aware of problems with the air conditioning on the 100 hall on 06/02/15 when the repair company rebooted the outside chiller. He reported there were still problems with the air conditioning so he called another repair company on 06/22/15, and they claimed the problem was a bad gauge. On 06/23/15 the MM commented he realized the air flow on the 100 hall was still not as cool as it should have been. According to the MM, on 06/26/15 the repair company identified bad chiller flow switches as the problem, and bypassed them until new ones could be installed on 06/30/15. He stated there were still problems with the air conditioning, and on 07/14/15 three return lines were installed in the hallway. On 07/23/15 the MM reported duct work from the unit at Station #1 was identified as the problem because it was not large enough, and had to be refabricated and rebuilt. The MM commented the facility purchased six window units to install in the hottest rooms on the hall. The MM explained there were still problems, and on 07/28/15 the front heat coil was removed because it was corroded, and air

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F 257	Continued From page 7	F 257		

could not move through it. The MM stated the hottest temperature he got using a temperature gauge gun in resident rooms was 83 degrees Fahrenheit on multiple occasions. He explained everytime the temperature reached the 83 degree mark he called the repair company back or in the end purchased window air conditioners for some of the rooms. The MM reported residents and family members were complaining about the heat.

At 12:48 PM on 08/07/15 the administrator stated the facility placed a large fan at the end of the 100 hall in early June 2015, and purchased six window air conditioners on 07/23/15. She stated she was not aware of any residents having to be moved due to the heat, and was not aware of any grievances about the heat. She explained the facility kept thinking each of the different repairs was going to fix the air conditioning problem at Station 1.

At 1:08 PM on 08/07/15 the MM stated he realized there was an ongoing problem with the air conditioning system at Station 1 on 06/30/15 when the replacement of the chiller flow switches did not seem to fix the heat issue. He explained the air blowing into the 100 hall registered in the 70s and should have been blowing in the 60s.

At 2:02 PM on 08/07/15 NA #6, who worked on the 100/300 halls (Nurse Station #1), stated it was consistently hot on the 100 hall for a six week period. She reported residents and family members complained, but were told that repairs to the air conditioning were in process. She commented residents perspired a lot, and had to be given a lot of extra fluids.

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F 257	Continued From page 8 At 2:18 PM on 08/07/15 NA #7, who worked on the 100/300 halls (Nurse Station #1), stated the air conditioning was out on the 100 hall for about six weeks, and the hall thermometer registered from 80 to 87 degrees Fahrenheit on the hottest days. She commented residents perspired a lot, required extra fluids, and residents and family members complained about the heat. According to the NA, the staff thought at first showers might cool the residents down, but then realized they only increased the heat and humidity on the hall. At 3:43 PM on 08/07/15 a resident who did not wish to be identified stated his/her room on the 100 hall was so hot he/she felt like he/she could not get his/her breath. He/She reported he/she would sweat at night, and his/her sheets would be wet. He/She commented he/she repeatedly complained about the heat, and sat in front of the big fan at the end of the hall during the day. He/She stated the big fan did not blow cold air, but it least he/she got some relief from circulating air as opposed to no air flow in the room. (The resident's minimum data set documented he/she had no cognitive impairment).	F 257		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 312	F 312 ADL CARE PROVIDED FOR	9/4/15

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F 312	Continued From page 9 interviews, the facility did not provide adequate bathing and hygiene services for one of two residents, Resident #58, who were observed for bathing and incontinent care, leading to odor and skin redness. Findings included: A review of the quarterly minimum data set (MDS) assessment dated 06/04/2015 revealed that Resident #58, who was originally admitted to the facility on 10/21/2010 was re-admitted on 05/28/2015, was cognitively impaired and had partial list of diagnoses which included anemia, hypertension, a wound infection, an anxiety disorder, and diabetes mellitus. The same assessment indicated that Resident #58 had no signs or symptoms psychosis, no physical or verbal behaviors directed toward others, and no behaviors such as rejection of care. In addition, the resident was totally dependent upon staff, requiring the assistance of one staff member to provide bathing, incontinent care, and personal hygiene. The resident required two staff persons for bed mobility. Resident # 58's nursing care plan which was initiated upon admission on 10/21/2010 and last updated on 06/17/2010 did not include a goal or interventions to address the resident's need for assistance with bathing and personal hygiene. On 08/02/2015 at 4:55 PM, an observation of Resident #58 was made. Upon approaching the door of the resident's room, a strong odor of urine and perspiration were noted in the hallway before entering the room. The observation revealed Resident #58 was lying in her bed with the head of the bed elevated and the upper quarter side	F 312	DEPENDENT RESIDENTS Resident # 58 was showered by NA #14 and NA # 15 on 8/7/15 with observation by facility consultant. Resident will continue to receive necessary ADL care to include bathing and incontinence care. 100% audit was conducted on 8/19/15 by the facility consultant for all residents to include resident # 58 to ensure adequate bathing and hygiene services to include bathing and incontinence care were provided. All identified issues were addressed immediately by the facility consultant on 8/19/15 to ensure adequate bathing and hygiene services were provided. 100% inservice of all CNA¿s and licensed nursing staff to include NA #8, NA #9, NA #10, NA #14 and NA # 15, Nurse # 8, Nurse #10 and Nurse # 11 was initiated by the Facility Consultant regarding the need to provide adequate bathing and hygiene services to include bathing and incontinence care for all residents to be completed by 9/4/15. All new CNAs will be inserviced by the SDC during orientation regarding the need to provide adequate bathing and hygiene services to include bathing and incontinence care for all residents. Resident care observations will be completed by the SDC, DON, ADON, QI Nurse, and Nursing Supervisor for 10% of all residents to include resident # 58 to ensure Licensed Nurses and CNAs to include NA #8, NA #9, NA #10, NA #14 and NA # 15, Nurse # 8, Nurse #10 and Nurse # 11 are providing the necessary adequate bathing and hygiene services to	

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F 312	Continued From page 10 rails elevated. The resident's sheets appeared to be dry, but the odor of urine was accompanied by a pungent, sour odor. The roomamate's end of the room did not have as strong an odor. On 08/03/2015 at 12:49 am, the resident was observed to be in bed with the head of the bed elevated. The strong odor of urine and the pungent, soured odor remained. An observation of the resident's bathroom revealed there were no strong odors of incontinence or soured linen, and there were no soiled linens or soiled briefs noted in the bathroom or in the resident's room. Resident #58 was observed again on 08/04/2015 at 8:40 AM, and the odor of urine and perspiration remained; however the odor was less intense than during the two previous observations. On 08/06/2015 at 9:40 AM, an observation was made of a bed bath with incontinent care which was provided by a nursing assistant, NA #8. During the bath, a large pressure ulcer was observed underneath the resident's right breast which was bright red. NA #8 bathed the resident's face and neck using warm soap and water on a wash cloth, then patted dry. Another nursing assistant, NA #9, entered the room at 9:46 AM to assist NA #9 with the resident's bath. With assistance, NA #8 turned the resident to wash her back, underneath the abdominal fold, and in between the resident's thighs. Redness was noted on Resident #58's skin in between the thighs when they were bathed. In an interview with NA #8 following Resident #58's bath on 08/06/2017 at 10:30 AM, she stated that she usually tried to complete the resident's bed bath without assistance. NA #8 also stated	F 312	include bathing and incontinence care 3x wk x 4 weeks, weekly x 4 weeks then monthly x 2 months using a Resident Care Audit Tool. Retraining will be provided during the audit by the SDC, DON, ADON, and QI Nurse for any identified areas of concern. The Administrator will review the Resident Care Audit Tool weekly x 8 weeks then monthly x 2 months and initial for completion and to ensure all areas of concern were addressed. The results of the Resident Care Audit Tool will be compiled by the QI Nurse and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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that it was difficult to complete her bath because of the resident's large size, and that it was difficult to wash underneath the folds of her skin on her breasts, abdomen, and thighs. In addition, she stated that the resident's urine often had a strong odor.

During an observation of pressure ulcer care for Resident #58 on 08/06/2015 at 11:10 AM, Nurse #10 completed a skin assessment with the assistance of NA #9 and Nurse #11. Redness was noted underneath the left breast and continuing toward the midline of the chest. Redness was also noted in between the resident's contracted left arm and her left side of her breast, as well as in between her upper thighs. Nurse #10 stated that moisture due to incontinence and perspiration were probably factors which led to the redness, as well as pressure.

A review of the Documentation Survey Reports for May 2015, June 2015, and July 2015 revealed the resident had received a shower on May 4, 2015, and that no other showers had been provided during the month of May 2015, June 2015, or July 2015. Documentation was not completed for day shift on May 1, 2015, May 19, 2015, May 29, 2015, June 10, 2015, June 12, 2015, and June 14, 2015 through June 16, 2015, June 25 through June 26, 2015, July 1, 2015, July 4, 2015, and July 11, 2015, July 12, 2015, July 31, 2015, and August 1, 2015 through August 5, 2015. In addition, documentation for bathing was incomplete for the following times: evening shifts on May 5, 2015, May 15, 2015, June 1, 2015, June 15, 2015, July 1, 2015, July 2, 2015, July 15, 2015, and July 27, 2015. Also, there was incomplete documentation on night shiftsa total of

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4 times over the months of May, June, July, and August 2015. It was noted that the Documentation Survey Reports for August 1, 2015 through August 6, 2015 revealed that no showers had been documented for the resident on any shift. The documentation revealed that Resident #58 had received a partial bath on 08/01/2015 on the 3:00 PM to 11:00 PM shifts on August 1, 2015, and a full bed bath on 08/06/2015.

In an interview with NA #10 on 08/07/2015 at 11:12 AM, she stated she had been assigned to the resident on most days recently, and that she had not ever provided a shower for the resident, and that the resident was assigned to have a shower one day per week, but that a shower was not scheduled for that day, 08/07/2015.

An interview was conducted with Nurse #10 on 08/07/2015 at 3:10 PM. During the interview, she stated that a thorough bath for Resident #58 would require 2 staff persons in order to clean in between all skin folds, including the thighs and underneath the left arm, due to the resident's size. The treatment nurse explained that it was not possible to provide wound treatments properly without 2 staff persons, and that the same would be true for bathing, and that it would be very difficult to hold skin back while at the same time wash thoroughly in between all skin folds. In addition, she stated that a shower would be the way to provide the most thorough bathing.

During an interview with Nurse #8 on 08/07/2015 at 3:58 PM, she provided the shower list kept at the nurse's station. Nurse #8 explained that the resident was scheduled to receive a shower on 08/04/2015 (Tuesday) and on 08/07/2015

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F 312	Continued From page 13 (Friday.) In addition, she stated that most residents in the facility were scheduled to receive showers twice per week, unless it was their preference to receive bed baths only. A review of the resident's nursing care plan on 08/07/2015 revealed the care plan had been updated on 08/07/2015 to include a focus on the need for assistance for all activities of daily living except eating related to impaired mobility and cognitive impairment. The goal was that the resident would be neat, clean, and odor free through the next review date. The intervention for this focus and goal included on the updated care plan was to provide constant supervision and 2 person assistance with all activities of daily living except eating. On 08/07/2015 at 4:40 PM, an observation of a shower provided for Resident #58 by NA #14 and NA #15 was made. Resident #58 received the shower without any problems noted. There was no observation of combative behaviors by the resident during the shower. In an interview with the Director of Nursing on 08/07/2015 at 5:30 PM, she stated that the resident had exhibited behaviors such as resistance to care, and that this might account for the difficulty of providing thorough bathing which might have led to body odors.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		9/4/15

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F 315	Continued From page 14 resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility did not have medical justification for an indwelling urinary catheter for 1 of 2 residents (Resident #122) who had indwelling urinary catheters. The facility also failed to ensure the physician was notified of final urinalysis and culture and sensitivity (C & S) results in order to make treatment decisions for 1 of 1 sampled residents (Resident #63) who experienced urinary tract infections (UTIs). Findings included: 1. Resident #122 was admitted to the facility on 02/19/15. He was re-admitted on 04/01/15 with an indwelling urinary catheter. Cumulative diagnoses included hypertension, chronic renal failure and depression. There was no mention of an indwelling urinary catheter in the Admission Minimum Data Set (MDS) assessment of 02/26/15. The history and physical of 03/31/15 noted Resident #122 was re-admitted after a hip fracture and was incontinent of urine. A health status note of 04/01/15 at 6:29 PM noted that Resident #122 had re-entered the facility from the hospital with an indwelling urinary	F 315	F 315 NO CATHETER The indwelling urinary catheter was discontinued for resident # 122 on 8/5/15 by the licensed nurse after contacting the physician regarding medical justification. Resident # 63 is no longer a resident at the facility. 100% audit was initiated on 8/18/15 by the facility consultant to ensure that all residents with indwelling urinary catheters had appropriate medical justification for the use of urinary indwelling catheters. Audit completed on 8/19/15. All identified problems were immediately addressed by the facility consultant on 8/18/15 and 8/19/15 by contacting the physician to obtain medical justification for the use of the urinary indwelling catheter and or orders to discontinue the use of the catheter if no current medical justification could be found. 100% audit was conducted by the facility consultant to ensure that the physician was notified of all physician ordered laboratory results, to include urinalysis and culture with sensitivity laboratory results from 3/31/15 through 8/10/15 completed on 8/20/15. All identified concerns were addressed by the facility consultant by notifying the	

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F 315	Continued From page 15 catheter and a 0.5 centimeters by 0.5 centimeters penile split. The flow sheet of non-ulcer skin conditions form dated 04/02/15 noted that Resident #122 had an indwelling urinary catheter. The quarterly MDS assessment of 05/29/15 noted Resident #122 had an indwelling urinary catheter. Resident #122's care plan of 06/09/15 identified problems with altered pattern of elimination related to an indwelling urinary catheter. Staff were to ensure that the drainage tubing was secured with an anchoring device. During an interview with Nurse #1 on 08/03/15 at 10:15 AM, she stated she was unable to locate a medical diagnosis for Resident #122's indwelling urinary catheter but he did have chronic renal failure. The flow sheet of non-ulcer skin conditions form of 08/03/15 noted Resident #122 had an indwelling urinary catheter with penile split. A health status note of 08/05/15 at 12:06 PM noted to discontinue the "foley" catheter (indwelling urinary catheter) and to monitor urine output for 3 days. Resident #122 was observed sitting in her wheelchair in the hallway on 08/05/15 at 1:30 PM. There was a privacy drainage bag noted to be hanging from underneath his wheelchair with catheter tubing. A physician's telephone order of 08/05/15 noted to discontinue the "foley" (indwelling urinary	F 315	physician of any laboratory results to include urinalysis and culture and sensitivity laboratory results that did not have a physician signature indicative of notification. 100% inservice was initiated for all licensed nursing staff, to include Nurse # 1, Nurse #2, and Nurse #3, regarding the need to ensure that all residents with indwelling urinary catheters have medical justification for the use of the catheter. A 100% inservice was also initiated for all licensed nursing staff, to include Nurse #4, Nurse #5, by the facility consultant on 8/18/15 on the need to notify the physician timely of any abnormal laboratory reports to be completed by 9/4/15. All new licensed nursing staff will be inserviced during orientation by the SDC regarding the need to ensure that all residents with indwelling urinary catheters have medical justification for the use of the catheter and of the need to notify the physician timely of all laboratory reports to include abnormal urinalysis and culture and sensitivity. When a resident is admitted to the facility with a urinary indwelling catheter or a current resident to include resident # 122 has a new catheter, the licensed nurse will check to ensure that medical justification is present for the use of the indwelling catheter. If no medical justification is present or found in the clinical record the physician will be immediately contacted by the licensed nurse to obtain appropriate indication for catheter use and or need to discontinue. A 100% audit of newly ordered indwelling urinary catheters to	

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F 315	Continued From page 16 catheter) and monitor urine output for 3 days. During an observation of personal care, on 08/06/15 at 10:30 AM, Nurse Aide #1 (NA #1) was preparing to provide a bed bath. He removed the bed covers and explained to Resident #122 that he was going to provide catheter care. It was noted that the indwelling urinary catheter had been removed. NA #1 asked Resident #122 what happened to his catheter and he responded that it had been taken out. NA #1 stated he had urinated in her brief and needed to be changed. During an interview with Nurse #3, on 08/06/15 at 2:45 PM, she stated that Resident #122's indwelling urinary catheter had been removed yesterday due to the realization that he had no supporting medical diagnosis for it. She stated he had gone out to the hospital a while back and returned with the catheter. Nurse #3 also stated that it should have been removed before now and a voiding trial should have been done to see if he had urinary retention. During an interview with Nurse #2, on 08/07/2015 at 11:00 AM, she stated it was the hall nurse's responsibility to find justification for a catheter when a resident was admitted to the facility with an indwelling urinary catheter. She stated if the nurse was unable to find a supporting diagnosis for the catheter the nurse should telephone the physician to get an order to remove the catheter and monitor urine output for 3 days. Nurse #2 stated Resident #122 had gone out to the hospital in April 2015 and came back to the facility with the indwelling urinary catheter.	F 315	include newly admitted or current residents will be conducted by the facility consultant, ADON, and SDC, and treatment nurse weekly x 8 weeks then monthly x 2 months using an Indwelling Catheter Audit Tool. All concerns will be addressed immediately by the facility consultant, DON, ADON and SDC and reeducation will be provided to the licensed nurses. The Administrator will review the results of the Indwelling Catheter Audit Tool and Laboratory Monitoring Tool weekly x 8 weeks then monthly x 2 months and initial to ensure completeness and that all identified concerns are addressed. When a laboratory result is received the QI Nurse, Nursing Supervisor or licensed floor nurse will ensure that all laboratory results, to include abnormal urinalysis and culture with sensitivity results are reviewed by the physician in a timely manner via fax, telephone, or by placing results in the physician communication box. A 100% audit of all new physician laboratory orders will be conducted by the, ADON, and SDC, using a Laboratory Monitoring Tool weekly x 8 weeks then monthly x 2 months using an Indwelling Catheter Audit Tool. All concerns will be immediately addressed by the ADON and SDC with reeducation provided to the licensed nurse. The Administrator will review the results of the Indwelling Catheter Audit Tool and Laboratory Monitoring Tool weekly x 8 weeks then monthly x 2 months and initial to ensure completeness and identified concerns were addressed. The results of the Indwelling Catheter	

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F 315	Continued From page 17 2. Resident #63 was admitted to the facility on 02/09/15 and discharged to the hospital on 05/23/15. The resident's diagnoses included indwelling catheterization and urinary retention. On 02/21/15 "Altered pattern of urinary elimination with indwelling catheter (urethral) r/t (due to) chronic urinary retention--at risk for infection" was identified as a problem in the resident's care plan. Interventions to this problem included "Obtain labs as ordered and notify physician of abnormal findings." A 03/30/15 progress note documented, "(Indwelling) catheter was patent and intact, no edema, redness or drainage at insertion site, draining yellow urine." A 03/31/15 physician's order requested that a urinalysis (UA) and culture and sensitivity (C & S) be completed for Resident #63. A 3/31/15 progress note documented, "Resident (#63) found on floor, laying on right side of his bed, unobserved fall from low bed, UA, C & S also collected." Review of a hard copy and an electronically signed copy of the lab results revealed Resident #63's C & S results were available on 04/04/15, and the sample contained greater than 100,000 colony forming units (CFU) chryseobacterium and an enterococcus species. There were no physician initials or staff initials on either copy of the results indicating that they had been relayed to or reviewed by the physician, there was no progress note documenting the results or	F 315	Audit Tool and Laboratory Monitoring Tool will be compiled by the QI Nurse and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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physician reponse to the results, and there was no physician order generated by the results.

The resident's 04/30/15 quarterly minimum data set (MDS) documented his cognition was severely impaired, he required extensive assistance from a staff member with toilet use, and he had an indwelling catheter.

Review of lab results documented on 05/01/15 a urine specimen collected from Resident #63 was received by the lab. On 05/05/15 C & S results documented the resident's specimen contained greater than 100,000 CFU of escherichia coli and proteus mirabilis bacterias.

A 05/05/15 physician's order started Resident #63 on Rocephin antibiotic, one gram intramuscularly (IM) daily x seven days. Review of the resident's medication administration record revealed he received the Rocephin as ordered.

A 05/23/15 progress note documented Resident #63 was alert and nonverbal, his vital signs were stable, the resident could not swallow medication, food, or fluids, and he was sent to the hospital due to a critical blood urea nitrogen level of 92 milligrams per deciliter (mg/dL) with normal being 6 - 23 mg/dL.

At 11:13 AM on 08/06/15 Nurse #4 stated hall nurses or unit managers collected lab results. She reported when she received results if the physician was in the building the notification would be verbal, and if not in the building, the physician would be notified via phone. She commented the staff member who notified the physician was supposed to note this contact on the lab result and/or in a progress note.

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F 315	Continued From page 19 According to Nurse #4, the physician initialed the lab results, even if he or she was notified via phone, to indicate the results were reviewed. At 12:04 PM on 08/06/15 Nurse #5, responsible for labs in the facility, stated the hall nurse, a supervisory nurse, or she herself would notify a physician of abnormal lab values (such as a UA with greater than 100,000 CFU of bacteria). She reported on the lab result the staff member who received it should document when the physician was notified and indicate whether any new orders were generated. She commented that lab results should not really be scanned into the electronic system unless they had nurse and physician initials on them indicating that the results were communicated to and reviewed by the physician. At 12:52 PM on 08/07/15 the director of nursing (DON) stated lab results were faxed to the facility and the hall nurses or unit supervisors picked them up. She reported whoever picked up the results was responsible for calling the physician to notify him or her of results. She commented this communication was supposed to be noted on the lab results and in a progress note. According to the DON, if no new orders were generated by the lab results then this information was also supposed to be documented on the lab results and in a progress note.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		9/4/15

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F 329	Continued From page 20 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that an at once (STAT) Depakote level was relayed to and discussed with the physician in order that he might make dosage adjustment decisions for 1 of 5 sample residents (Resident #214) reviewed for unnecessary medications. Findings included: Resident #214 was admitted to the facility on 02/21/14 and readmitted to the facility on 03/12/14 and 07/29/14. The resident's documented diagnoses included bipolar disorder. On 11/20/14 "Use of psychotropic drugs with the potential for side effects r/t dx (due to diagnoses) of insomnia, bi-polar" was identified as a problem	F 329	F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS The physician was notified of Valproic Acid level drawn 6/17/15 on 8/6 15 by the QI Nurse, and an order for a stat Valproic Acid Level was obtained for resident # 214 from the physician and drawn by the QI Nurse on 8/6/15. The physician was notified of the results of the stat Valproic Acid Level via telephone by the QI Nurse on 8/6/15 and results discussed with the physician. 100% audit was conducted by the facility consultant to ensure that the physician was notified of all physician ordered laboratory results, to include abnormal	

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F 329	Continued From page 21 in the resident's care plan. Interventions to this problem included, "Administer medications per physician's orders", "Monitor resident for mood/behaviors (refusing care, demanding, verbal aggressive behaviors) with documentation per facility policy and notify physician of any significant changes", and "Monitor resident's mental status functioning on ongoing basis." The medication administration record (MAR) documented the resident was started on Depakote 500 milligrams (mg) nightly (Q HS) on 03/02/15. A lab result documented the resident's Depakote level was low on 03/24/15 at 38.2 micrograms per milliliter (ug/mL) with the normal range being 50 - 100 ug/mL. The resident's 05/07/15 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no signs of psychosis, had no behaviors, and did not resist care or wander. Review of progress notes from 06/02/15 through 06/17/15 documented Resident #214 yelled at staff, demanded information about other residents' medical status, threatened to have staff fired, and resisted care. A 06/17/15 progress note documented, "Resident is OOF (out of facility) this AM...to ____ (name of clinic) for psych evaluation. Returned to facility with new orders for Depakote ER (extended release) 500 mg Q HS and Celexa (anti-depressant) 20 mg Q AM. I called back...and spoke with ____ (name of physician), asked him if he meant to put resident on medication that was already on that was not	F 329	laboratory results from 3/31/15 through 8/10/15 completed on 8/20/15. All identified concerns were addressed by the facility consultant by notifying the physician of any laboratory results on 8/20/15 to include abnormal laboratory results that did not have a physician signature indicative of notification. A 100% inservice was also initiated for all licensed nursing staff, to include Nurse #4, Nurse #5, by the facility consultant on 8/18/15 on the need to notify the physician timely of all laboratory results to include abnormal laboratory results to be completed by 9/4/15. All new licensed nursing staff will be inserviced by the SDC during orientation concerning the need to notify the physician timely of all laboratory results to include abnormal laboratory results. When a laboratory result is received the QI Nurse, Nursing Supervisor, or licensed floor nurse will ensure that all laboratory results are reviewed by the physician in a timely manner via telephone, fax, or by placing results in the physician communication box with documentation of notification in the clinical record. The DON, ADON, and SDC will conduct an audit of all physician ordered labs weekly x 8 weeks then monthly x 2 months using a Laboratory Monitoring Tool to ensure the physician has been notified of all laboratory results in a timely manner. All areas of concern will be immediately addressed by the DON, ADON and SDC by contacting the physician regarding laboratory results and providing retraining. The Administrator will review the results of	

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F 329	Continued From page 22 working..._____ (name of physician) then ordered a STAT Depakote level to be drawn and results faxed to his office. Specimen was drawn by lab nurse, but I have not seen the results yet." Review of hard copies in the medical record and scanned lab results in the electronic record revealed the facility did not have the lab result associated with Resident #214's STAT Depakote lab draw. Review of progress notes revealed there was no further documentation about lab results for the resident's 06/17/15 Depakote draw. The resident's 07/10/15 annual MDS documented her cognition was intact, she exhibited no signs of psychosis, had no behaviors, and did not resist care or wander. At 11:00 AM on 08/06/15 the facility obtained a copy of the results from Resident #214's 06/17/15 Depakote lab draw. The resident's Depakote level dropped to 36.6 ug/mL (lower than the 38.2 ug/mL obtained on 03/24/15). At 11:13 AM on 08/06/15 Nurse #4 stated hall nurses or unit managers collected lab results. She reported when she received results if the physician was in the building the notification would be verbal, and if not in the building, the physician would be notified via phone. She also remarked there were times when physicians might want results faxed to them. She commented the staff member who notified the physician, via phone or fax, was supposed to note this contact on the lab result and/or in a progress note. According to Nurse #4, if the physician was faxed then he would initial the results and	F 329	the Laboratory Monitoring Tool Weekly x 8 weeks then monthly x 2 months and initial to ensure completeness and ensure all identified areas of concern have been addressed. The results of the Laboratory Monitoring Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 329	Continued From page 23	F 329		

document any new orders or the lack of any new orders based on the results. She explained the physician would then fax the facility back with his initials and remarks on the results, and medical records would scan the doctor's fax back to the facility into the electronic system.

At 12:04 PM on 08/06/15 Nurse #5, responsible for labs in the facility, stated the hall nurse, a supervisory nurse, or she herself would notify a physician of abnormal lab values (such as a Depakote level below the normal range). She reported on the lab result the staff member who received it should document when the physician was notified and indicate whether any new orders were generated.

At 12:52 PM on 08/07/15 the director of nursing (DON) stated lab results were faxed to the facility and the hall nurses or unit supervisors picked them up. She reported whoever picked up the results was responsible for communicating the results to the physician. She commented this communication was supposed to be noted on the lab results and in a progress note. According to the DON, if no new orders were generated by the lab results then this information was also supposed to be documented on the lab results and in a progress note. The DON provided a copy of a STAT Depakote level drawn for Resident #214 on 08/06/15. The resident's Depakote level was 34.4 ug/mL, below the normal range and the 36.6 ug/mL obtained on 06/17/15. The DON stated a meeting with the resident's physician regarding psychotropic medication management was pending.

At 2:10 PM on 08/07/15 a message was left for the physician following Resident's #214's

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F 329	Continued From page 24 psychiatric health at the clinic, but the physician never returned the call.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide 1 of 4 sampled residents (Resident #74), reviewed for nutrition, with physician-ordered enriched meals (featuring foods prepared with high calorie, nutrient dense ingredients such as cheese, milk, and cream). Findings included: Resident #74 was admitted to the facility on 06/04/15. His diagnoses included hypertension, cerebrovascular accident, myocardial infarction, and dysphagia. The resident's Weight Summary documented he weighed 144 pounds on 06/05/15. On 06/10/15 the resident's care plan identified "State of nourishment: less than body requirement characterized by weight loss, inadequate intake, decreased appetite related to: being on mechanically altered diet, leaves 25% of most meals uneaten" as a problem. Interventions to the problem included providing the "diet as ordered." The resident's 06/11/15 admission minimum data set (MDS) documented his cognition was	F 367	F367 Therapeutic Diet Prescribed by Physician This resident has since been discharged from the facility. A 100% audit of all resident physician ordered diets was conducted by the facility consultant comparing actual physician orders to dietary tray cards to ensure correct diet was being served. All inconsistencies were immediately corrected by the facility consultant and dietary manager. Audit completed on 8/20/15. The Dietary Manager and Dietary Assistant were inserviced on 8/11/15 by the Administrator on the need to ensure that diets are correctly entered into the Tray Tracker system when dietary slips are received. All new dietary management personnel will be inserviced by the SDC on the need to ensure that diets are correctly entered into the Tray Tracker system when dietary slips are received. When a dietary slip is received from the nursing department that indicates a change in a resident¿s diet, the Dietary Manager or Dietary Assistant will update	9/4/15

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F 367	Continued From page 25 moderately impaired, he required limited assistance by a staff member with eating, he had no swallowing difficulty, his weight was stable, and he was on a mechanically altered diet. A 06/18/15 Wound Ulcer Flowsheet documented Resident #74 developed a stage II pressure ulcer to his sacrum. A 06/18/15 RD (registered dietitian) progress note documented the resident was on a mechanical soft diet with meal intake varying between 25 - 100%. A 07/09/15 Wound Ulcer Flowsheet documented Resident #74's sacral pressure ulcer was healed. The resident's Weight Summary documented the resident weighed 139 pounds on 07/16/15 and 07/20/15. A 07/23/15 RD progress note documented Resident #74 had lost five pounds since admission, his meal intake was 75 - 100%, and his pressure ulcer was healed. The RD recommended Resident #74 be placed on the enriched meal program (EMP) "to aid in weight stability/meeting needs." A 07/23/15 physician order placed the resident on the EMP. Resident #74's Weight Summary documented he weighed 142 pounds on 07/31/15. At 4:38 PM on 08/05/15 the dietary manager (DM) pulled Resident #74's meal/tray slips up on the computer. They documented the resident was on a regular mechanical soft diet. There was	F 367	the tray tracker card system to indicate resident¿s current physician ordered diet. The Registered Nurse (RN) Administrator will review all new physician¿s orders and diet slips and compare to tray tracker diet cards to ensure correct diet is being provided to the resident using a QI Diet Order Monitoring Tool daily Monday through Friday x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. Reeducation will be immediately provided by the RN Administrator for any identified areas of concern. The Regional Vice President (RVP) will review the Diet Order Monitoring Tool weekly x 8 weeks then monthly x 2 months to ensure complete and any concerns were addressed. The results of the Diet Order Monitoring Tool will be compiled by the Administrator and presented to the Quality Improvement Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 367	Continued From page 26 no documentation that the resident was to receive enriched meals. At 10:47 AM on 08/06/15 the DM stated the only way the dietary staff preparing resident plates would know if residents were on the EMP was by documentation on the meal/tray slips. She explained a dietary employee on the trayline called out the diet specified on the tray slip so the person placing food on the plates could honor the diet prescription. The DM commented nursing communicated diet order changes or additions by completing a dietary communication form. According to the DM, one of these forms was completed for Resident #74, but the dietary department did not change the resident's diet prescription in the computer system which generated the tray slips.	F 367		