

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345547	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2017
NAME OF PROVIDER OR SUPPLIER CAMDEN HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1 MARITHE COURT GREENSBORO, NC 27407	
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F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to ensure the Minimum Data Set (MDS) was accurate for one of two sampled residents with dialysis (Resident # 368 was not assessed as having dialysis) and one of three sampled residents that was discharged (Resident # 119 was not assessed as being discharged to home.)</p> <p>The findings included:</p> <p>1. Resident #368 was admitted to the facility on 10/26/17 with diagnosis that included end stage renal disease with hemodialysis.</p> <p>Review of the admission Minimum Data Set (MDS) dated 11/2/17 revealed the assessment did not include dialysis as a treatment for Resident #368.</p> <p>Interview with MDS Nurse #2 on 12/8/17 at 12:09 PM revealed that was in error and should have been coded on the assessment. She explained a part time MDS nurse had completed the MDS and she did not know how it was missed.</p> <p>2. Resident #119 was admitted to the facility on 9/1/17 with diagnosis that included pneumonia.</p> <p>Review of the discharge Minimum Data Set (MDS) dated 9/19/17 indicated Resident #119 was discharged to a local hospital.</p>	F 641	<p>The facility is responsible for ensuring that the MDS assessment for each resident accurately reflects the resident's status. The MDS nurse uses record reviews, staff interviews, and resident observation to ensue the MDS accurately reflects the resident's status. The facility MDS nurse failed to code dialysis on the MDS assessment dated 11/2/17 for resident #368 due to an oversight. The facility MDS nurse failed to code discharge home on the 9/19/17 MDS for resident #119 due to an oversight.</p> <p>The 11/2/17 MDS assessments for resident #368 will be modified to reflect that the resident was on dialysis and a correction sheet will be submitted by 1/5/18. The MDS assessment for resident #119 will be modified to reflect that the resident was discharged to home and a correction sheet submitted by 1/5/18.</p> <p>A 100% audit of sections O0100J and A0310 for all resident's most recent MDS will be completed by the facility MDS consultants or MDS nurses to ensure coding accurately reflects the resident's status by 1/5/18. For any areas of concern identified, a modification or significant correction will be completed by the facility MDS nurse or MDS nurse</p>	1/5/18

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

TITLE

(X6) DATE

Electronically Signed

12/29/2017

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 641	Continued From page 1 Review of the nurse ' s notes dated 9/19/17 indicated Resident #119 was discharged home with her daughter. Interview on 12/8/17 at 12:09 PM MDS Nurse #2 reviewed the discharge MDS and confirmed it was inaccurate. The MDS nurse #2 explained it was coded in error.	F 641	consultant by 1/5/18. All disciplines responsible MDS coding will be educated regarding accurate coding of MDS assessments per the RAI manual by 1/5/18. Facility MDS consultant will audit 10 percent of all MDS completed each week for four for weeks accuracy in all sections. All areas identified to be of concern will be addressed immediately by the MDS consultant with retraining of appropriate staff making the error. MDS nurse will complete modifications or significant correction to assessments as indicated. A QI tool will be utilized. QI audit tools will be submitted to the QI committee for review monthly for three months for review and revision of the plan as indicated.		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		1/5/18	

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F 655	<p>Continued From page 2</p> <p>including, but not limited to-</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews, the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident with a Foley catheter, pressure ulcer and requiring the use of oxygen for 1 of 3 (Resident # 327) residents reviewed for baseline care plans.</p>	F 655	<p>The facility is responsible for developing a baseline care plan that reflects the residents current status. The facility nursing staff includes at least the minimum healthcare information to properly care for a resident. The facility failed to include the presence of a pressure ulcer, the use of a catheter and</p>		

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F 655	<p>Continued From page 3</p> <p>Findings included:</p> <p>Resident # 327 was admitted to the facility on 12/1/17 from the hospital with diagnosis of: Right femur fracture, HTN, A-fib, CKD, History of falling, BPH, Constipation, Alzheimers, Depression, GERD, COPD and Malnutrition.</p> <p>An Admission/5 day Minimum Data Set (MDS) was opened but had not been completed at the time of the survey. Resident #327 was cognitively impaired and required extensive assistance with bed mobility, dressing, hygiene, transfers, bathing and eating.</p> <p>An observation of the resident on 12/4/17 at approximately 4:30 PM revealed resident lying in bed with a catheter drainage bag secured to his left leg and a nasal cannula connected to an oxygen concentrator.</p> <p>A review of the physicians' orders for December, 2017 revealed an order for Oxygen 3 liters per minute via nasal cannula at all times to keep oxygen saturation above 92%.</p> <p>A record review on 12/5/17 at 4:38 PM revealed a treatment order to clean the pressure ulcer to sacrum with normal saline, pat dry, skin prep peri-wound and surrounding non-blanchable redness, allow to dry, apply Santyl ointment to open area, cover with 6x6 Allevyn bordered adhesive foam dressing, change daily.</p> <p>A record review on 12/6/17 at 4:38 PM revealed a 48 hour Interim Care Plan dated 12/1/17 for problems of: Discharge Plans, Nutritional Needs, ADL Decline, Risk for Abnormal Bleeding,</p>	F 655	<p>the use of oxygen for resident #327 due to an oversight.</p> <p>The admission care plan for resident #327 will be updated to include the presence of a pressure ulcer, the use of a catheter and the use of oxygen by 1/5/18.</p> <p>The facility MDS nurse will audit admission care plans for residents admitted in the last 21 days who still resident in the facility, for the presence of a pressure ulcer, the use of oxygen and the use of catheters. Care plans will be corrected as indicated and an updated care plan provided to the resident and responsible party by 1/5/18.</p> <p>The facility administrative nursing staff will be educated by the facility nurse consultant regarding the process for gathering information to develop the residents baseline care plan by 1/5/18.</p> <p>The facility MDS nurse will audit 10% of baseline care plans completed Weekly for four weeks for use of catheters, presence of pressure ulcers and oxygen. A QI tool will be utilized.</p> <p>Results of audits will be reported to the facility QA committee monthly for three months.</p>		

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

PRINTED: 01/09/2018
FORM APPROVED
OMB NO. 0938-0391

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F 655	<p>Continued From page 4</p> <p>Potential for Pain, Impaired Skin Integrity related to Surgical Wound, Risk for Decreased Cardiac Output, Psychotropic Drug Use, Risk for Falls, Right Hip Fracture, Risk for Infection, Risk for Constipation. Oxygen use, Indwelling catheter use and presence of actual skin breakdown were not care planned.</p> <p>A record review on 12/6/17 at 4:38 revealed an admission note dated 12/1/17 indicating Resident # 327 had an indwelling catheter draining and a pressure area to his sacrum.</p> <p>An interview conducted on 12/8/17 at 9:40 AM with the nurse that provided care to the resident revealed the care guide and morning report (verbal) are the tools used for communicating the resident's needs to the nursing assistants. She revealed the care guides are updated every shift and as needed by professional staff. When asked why the wound wasn't listed on the care guide, she revealed she did add it on during the admission process but that many people have access to them and someone may have removed it.</p> <p>An interview conducted on 12/8/17 at 9:54 AM with the Director of Nursing (DON) revealed she would have been the one to implement the resident's baseline care plan and revealed the pressure area, catheter and oxygen use got missed for this resident.</p> <p>An interview conducted on 12/8/17 at 10:15 AM with the facility Administrator revealed that her expectation was that care plans are accurate and updated to reflect the resident's needs.</p>	F 655			
F 657	Care Plan Timing and Revision	F 657		1/5/18	

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F 657 SS=D	Continued From page 5 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to update a care plan for one of four sampled residents with indwelling urinary catheters (Residents #79 and 75.) and failed to invite three of five sampled residents to the care plan meetings (Residents # 91, 79 and 35).	F 657	The interdisciplinary team develops a comprehensive care plan for each resident within seven days of the comprehensive assessment. The care plan is prepared with the participation of the resident and resident representative to the extent practicable. The facility did not update the care plan for resident #79		

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F 657	<p>Continued From page 6</p> <p>The findings included:</p> <p>1. Resident #79 was admitted to the facility on 10/3/17 with diagnosis of a stroke.</p> <p>Review of the care plan dated 10/4/17 included a problem with an onset date of 10/4/17 for use of an indwelling catheter. Approaches included for nursing to evaluate for removal of catheter.</p> <p>Review of the Minimum Data Set (MDS) an admission, dated 10/10/17 indicated Resident #79 had an indwelling urinary catheter. This MDS assessed the resident as having long and short term memory impairment.</p> <p>Observations on 12/5/17 at 3:35 PM revealed Resident #79 did not have an indwelling urinary catheter.</p> <p>Interview with the supervisor nurse on 12/6/17 at 1:00 PM revealed the resident did not an indwelling urinary catheter. Further interview revealed he did not have an order in the discharge summary from the hospital for the urinary catheter. Review of the admission orders with the supervisor nurse revealed he did not have an order for the catheter and he did not have an order to remove the catheter. The admission note included the resident had an indwelling urinary catheter on the admission assessment.</p> <p>Interview with the MDS nurse on 12/8/17 at 9:10 AM revealed she receives updates for care plans in the morning staff meetings. She explained the pink copy of the telephone orders would be provided. During the interview, she explained she was not aware Resident #79 no longer had the</p>	F 657	<p>upon removal of the resident's catheter. The facility MDS nurse failed to update the care plan because they were not aware the catheter had been removed. The facility failed to invite resident #75, #79, #91, and #35 to participate in the development of the comprehensive care plan because of an oversight.</p> <p>The care plan for resident #79 will be updated, removing the catheter use from the resident's care plan by 1/5/18.</p> <p>Resident #75, #79, #91, and #35 will be invited to participate in a care plan review with the IDT team by 1/5/18.</p> <p>Facility MDS nurse will review the care plan for all residents and make updates related to catheter use as indicated by 1/5/17.</p> <p>Facility social worker will provide the resident and the resident representative a letter indicating the date and time for each residents next scheduled quarterly care plan review by 1/5/17.</p> <p>Facility Social worker, MDS nurses, dietary manager and activity director will be educated on the requirement of resident care plan meetings to include a care plan review and revision and the requirement to involve the resident and resident representative in the care plan development when practicable by 1/5/18.</p> <p>SW, DON, Administrator or SDC will monitor to ensure residents and resident</p>		

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F 657	<p>Continued From page 7</p> <p>urinary catheter, as there was no pink copy of an order given to her.</p> <p>2. Resident #75 was admitted to the facility on 9/2/09 with diagnosis that included a neuromuscular disorder.</p> <p>Review of the most recent Minimum Data Set (MDS) dated 10/23/17 indicated Resident #75 had some problems with short term memory and no problems with long term memory. He had a BIMs (Brief Interview for Mental Status) of 11.</p> <p>In an interview with the resident on 12/6/17 at 9:15 AM revealed he had not been invited to attend a care plan meeting. During the interview, he expressed a desire to attend the meeting.</p> <p>On 12/06/17 at 4:32 PM an interview with Social Worker (SW) #2 revealed she did not have an invite for R #75 to attend a care plan meeting after the most recent quarterly MDS of 10/23/17. She further explained a care plan meeting was not held with the Inter Disciplinary Team after this MDS. She explained she had been the only SW until recently and the additional SW was responsible for sending out the invitations. It had not been routinely sent to residents, but to their responsible party. If the responsible party did not respond, a care plan meeting was not held.</p> <p>3. Resident # 91 was admitted to the facility on 2/10/17 with diagnosis that included stroke. Review of the most recent Minimum Data Set (MDS) dated 11/6/17 indicated Resident #91 had no long or short term memory impairments. Interview with Resident #91 on 12/06/17 at 8:40 AM revealed he didn ' t have any care plan meetings.</p>	F 657	<p>representatives are invited to care plan meetings scheduled three times weekly for four weeks. A QI tool will be utilized. Facility DON, ADON or nursing supervisor will monitor resident's who have catheters weekly for four weeks to ensure their care plan is updated as indicated. A QI tool will be utilized.</p> <p>Results of audits will be submitted to the facility quality team monthly for review.</p>		

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F 657	Continued From page 8 Interview on 12/6/17 at 4:37 PM with Social Worker #2 revealed a letter was addressed to him and she provided a copy of the letter. She explained SW #1 had prepared the letter and would have given it to him. She did not know if he responded or the family. Interview on 12/7/17 at 12:00 PM with Resident #91 revealed he had not received a letter. He further explained, if the letter went to his wife, it should have been given to him. Interview with Social Worker #1 on 12/8/17 at 10:45 AM revealed she had mailed the Responsible Party the care plan meeting notice. She further explained she had not been giving the invitations to the residents that were alert and oriented. 4. Resident #35 was admitted to the facility on 12/15/16 with diagnoses which included: diabetes mellitus, hypertension, dysphagia, and aftercare following joint replacement surgery. The quarterly MDS (minimum data set) dated 12/1/17 indicated Resident #35 was cognitively intact and had no behaviors. Resident #35's Care Plan was last reviewed by the facility's staff on 12/1/17. There was no documentation available indicating the resident or the resident's family attended or was invited to participate in setting goals and planning the resident's care. During an interview on 12/4/17 at 5:35p.m., Resident #35 stated that he did not recall being invited to any of his Care Plan meetings since his	F 657			

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F 657	Continued From page 9 admission. The resident indicated he was not included in making decisions about his medicine, therapy, or other treatments. During an interview on 12/6/17 at 4:26p.m., SW#1 (Social Worker #1) revealed that in preparation for residents' Care Plan meetings, letters would be mailed to residents' Responsible Parties and hand delivered to the alert and oriented residents, inviting them to the their quarterly Care Plan meeting to be held within a two week timeframe. However, if the resident or the resident's Responsible Party declined the invitation, then a Care Plan meeting would not be conducted for the resident. SW#1 confirmed there was no Care Plan meeting invitation given to Resident #35 or mailed to his Responsible Party.	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to have an order for the use of an indwelling catheter for 1 of 4 (Resident # 327) residents sampled for catheters. Findings included: Resident # 327 was admitted to the facility on 12/1/17 from the hospital with diagnosis of: Right femur fracture, HTN, A-fib, CKD, History of	F 658	The facility will ensure that all residents who use an indwelling catheter have an order for the use of a catheter. The facility failed to ensure resident #327 had an order for the use of his indwelling catheter due to lack of staff education. The facility obtained and order for the Foley catheter for resident #327. ADON conducted a 100% audit for all residents	1/5/18	

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F 658	<p>Continued From page 10</p> <p>falling, BPH, Constipation, Alzheimers, Depression, GERD, COPD and Malnutrition.</p> <p>An Admission/5 day Minimum Data Set (MDS) was opened but had not been completed at the time of the survey. Resident #327 was cognitively impaired and required extensive assistance with bed mobility, dressing, hygiene, transfers, bathing and eating.</p> <p>An observation of the resident on 12/4/17 at approximately 4:30 PM revealed resident lying in bed with a catheter drainage bag secured to his left leg.</p> <p>A record review on 12/5/17 at 4:38 PM of the physicians ' orders for December, 2017 did not indicate an order for an indwelling catheter.</p> <p>An interview conducted on 12/8/17 at 9:54 AM revealed it was her fault the resident did not have an order for the indwelling catheter. She revealed she would have been the one to communicate with the physician about the presence of an indwelling catheter.</p> <p>An interview conducted on 12/8/27 at 11:37 AM with the facility physician revealed that Resident #327 was admitted with an indwelling catheter. She revealed the facility should have done a voiding trial on admission to assess for continuance or removal. She further revealed there should have been an order for the catheter on admission.</p>	F 658	<p>with catheters to ensure each resident with a catheter has a physician order for the catheter by 1/5/18.</p> <p>Facility DON or SDC will educate nurses regarding the use of indwelling catheters to include the requirement of a physician order for catheter use by 1/5/18.</p> <p>Facility ADON will audit all residents with catheter's weekly for four weeks to ensure all residents have orders for the use of the catheter. A QI audit tool will be utilized.</p> <p>QI audit tools will be monitored monthly for three months by the facility QA committee.</p>		
F 676 SS=D	<p>Activities Daily Living (ADLs)/Mntn Abilities</p> <p>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)</p> <p>§483.24(a) Based on the comprehensive</p>	F 676		1/5/18	

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F 676	<p>Continued From page 11</p> <p>assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:</p> <p>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ¿</p> <p>§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations resident interview, staff interview and record review the facility failed to</p>	F 676	The facility provides appropriate treatment to maintain or improve each		

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F 676	<p>Continued From page 12</p> <p>provide restorative services to prevent a decline in Resident #91's ability to ambulate for 1 of 3 sampled residents receiving restorative services.</p> <p>The finding included:</p> <p>Resident #91 was admitted to the facility on 2/10/17 and readmitted on 7/30/17. Diagnoses included stroke, urinary tract infection, diabetes and hemiplegia of the dominant side.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 8/12/17 indicated Resident #91 required limited assistance of one staff for ambulation in the room and in the hallway, he required limited assistance with set up help for locomotion on the unit, he required limited assistance of one staff for personal hygiene and he required extensive assistance of one staff for bed mobility, transfers and toileting. Resident #91 could eat with supervision and set up help only. This MDS indicated Resident #91 had long and short-term memory intact.</p> <p>Review of the occupational therapy (OT) discharge summary dated 8/14/17 documented the "current" level of functioning for transfers and toileting was stand by assistance (close enough to reach patient if assist needed), for self-care the resident required minimal assistance for upper body and moderate assistance for lower body.</p> <p>The discharge OT summary dated 8/14/17 included the anticipated level of functioning for toileting and was "supervision or touching assistance with verbal cues or steadying assistance as the resident completed the activity", for transfers and toileting it was anticipated he would need verbal cueing but no physical</p>	F 676	<p>resident's activities of daily lining. The facility failed to deliver restorative services according to the resident's plan of care for resident #91.</p> <p>Resident #91 was re-evaluated by therapy and placed on caseload to address any decline by 12/10/17.</p> <p>Facility therapy manager conducted a 100% audit of residents who have restorative nursing services as a therapy recommendation.</p> <p>Facility ADON, MDS will review each resident's plan of care with a recommendation for restorative nursing services with the restorative nursing team before 1/5/18.</p> <p>SDC,DON or ADON will conduct resident care audits of at least 10% of residents on restorative caseload weekly for four weeks that includes resident interview, observation of resident care, and documentation. A QI tool will be utilized.</p> <p>Results of audits will be submitted to the monthly quality committee for review.</p>		

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F 676	<p>Continued From page 13</p> <p>assistance, and self-care was with supervision with verbal cueing but no physical assistance. The discharge plan included transfer to restorative nursing for right upper extremity range of motion for improvement in ability to assist with self care3 tasks, and safety during toilet transfers and tasks.</p> <p>Review of the Physical Therapy (PT) discharge summary dated 8/14/17 indicated he could ambulate 250 feet with stand by assistance. The anticipated level of functioning indicated he would require supervision but no physical assistance for ambulating 200 feet. The discharge plan included transfer of care to restorative nursing.</p> <p>Review of the quarterly MDS dated 11/9/17 indicated no impairment with short or long-term memory. Resident #91 required extensive assistance of two staff for mobility, transfers, extensive assistance of one staff for ambulation in the room and hallway, locomotion on the unit, toileting, personal hygiene and eating.</p> <p>Review of the "Facility Training Log" dated 8/14/17 indicated the restorative aide #3 was instructed in the plan of care for Resident #91. The training included gait with platform rolling walker, seated therapeutic exercises and bilateral upper extremities exercises using pulleys. The plan of care frequency was "5-6x (times)/wk (week)."</p> <p>Review of the "Nursing Restorative Care Place and Flow Record" dated August 2017 indicated the programs were gait with platform rolling walker with a goal of 200 feet twice (400 feet), active assist range of motion to bilateral lower extremities, with a goal to maintain strength for</p>	F 676			

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F 676	<p>Continued From page 14</p> <p>functional transfers, gait and bed mobility acts to decrease caregiver burden. The resident was to be seated in the wheelchair and perform 20 repetitions/2 sets of active assist range of motion to active range of motion on right lower extremity using no weights. Active range of motion on the left lower extremity with 5 pound weights. Other exercises included marches, hip adduction/ball squeezes, hip abduction and hamstring curls.</p> <p>Review of the care plan with a problem onset date of 8/21/17 for ambulation with a goal to ambulate 200 feet x 2 6 days per week with restorative to assist with gait training with platform rolling walker. A problem onset of 8/21/17 included weakness of bilateral lower extremities with a goal for the resident to maintain strength for functional transfers gait and bed mobility with restorative assisting the resident seated in the wheelchair and perform lower extremity exercises of marches, hip adduction/ball squeezes, hip abduction, hamstring curls 6 days a week.</p> <p>Review of the documented restorative minutes from 11/22/17 to 12/6/17 indicated he received Range of motion (active and passive) for 15 minutes for each exercise for 5 days in a two-week timeframe. The documentation did not include specifics related to the plan of care for restorative. The extremity(ies) and type of active exercises were not described. Resident #91 ambulated 5 days for 350 to 400 feet. The last documented date Resident #91 received restorative was on 12/1/17.</p> <p>Review of a PT evaluation dated 12/7/17 revealed Resident #91 had a decline in functional abilities of bed mobility, transfers and gait due to strength deficits of right lower extremity, decreased</p>	F 676			

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F 676	<p>Continued From page 15</p> <p>standing balance, decreased postural control and decreased safety awareness resulting in increased risk for falls, decreased safety and an increased need for assistance. Therapy would be necessary for the resident to improve quality of gait, increase right foot clearance, improved reciprocal coordination of bilateral lower extremities, increase lateral stability, increase strength of right lower extremities, increase standing balance, postural control, increase activity tolerance and increase safety awareness to decrease risk for falls and increase functional mobility. The current level of functioning for ambulation indicated he required contact guard due to unsteadiness for safe ambulation for 150 feet.</p> <p>Observations of Resident #91 during the survey revealed he was seated in his wheelchair. He was not observed ambulating at any time.</p> <p>Interview with Resident #91 on 12/6/17 at 8:48 AM revealed he had declined in his ability to walk. Further interview revealed he was weak in his legs and arms. During the interview, he explained restorative had not provided his treatment of ambulation and exercises every day as scheduled. Resident #91 explained it had been "days" since he had walked with restorative. Further interview revealed he did not know why, unless they did not have enough staff. Resident #91 further stated the "staff" did not want him walking without assistance, and he had to use the wheelchair for mobility due to a fall several months ago.</p> <p>Interview with Restorative Aide (RNA) #1, who provided restorative services to Resident #91 was conducted on 12/7/17 at 12:00 PM. RNA #1</p>	F 676			

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F 676	<p>Continued From page 16</p> <p>explained the resident was to have lower extremity exercises with the exercise band, ambulate to the gym where he did 3 sets of exercises with the pulleys. She further explained he was to have his restorative treatments every day. RNA #1 explained she did not do the exercises/ambulation on 12/4/17 but he received his treatment on 12/6 and 12/7/17. She further explained Resident #91 had never refused his treatments. RNA #1 did not explain why the treatments had not been done when asked. She did explain there had been a problem with staffing in the previous months, but not in the last month.</p> <p>Interview with the Assistant Director of Nursing on 12/7/17 at 12:05 PM revealed no explanation could be provided as to why the plan of care had not been provided to Resident #91.</p> <p>Interview on 12/8/17 at 9:00 AM with the Director of Nursing revealed she would have to check as to why Resident #91 did not receive his exercises and ambulation. An explanation was not provided.</p> <p>Interview with the Administrator and Corporate Regional on 12/8/17 at 3:45 PM indicated they did not think Resident #91 had experienced a decline. The Corporate Regional explained bed mobility was not part of the restorative plan and he had a difference of 50 feet in ambulation which did not signify a decline. The difference in the plan of care for exercises between the interview with the RNA#1 and the written plan was not explained by either.</p>	F 676			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		1/5/18	

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F 677	<p>Continued From page 17</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide personal hygiene for 2 of 4 sampled residents dependent on staff for care. Resident # 76 did not receive incontinent care and Resident #91 did not receive weekly scheduled showers.</p> <p>The findings included:</p> <p>1. Resident #76 was admitted to the facility on 10/1/17 with diagnosis that included a blood disorder and end stage renal disease. Review of the significant change Minimum Data Set (MDS) dated 10/8/17 indicated Resident #76 was occasionally incontinent of bowel and bladder, required extensive assistance of one person for toileting and had no impairment with long or short- term memory. Review of the care plan dated 10/17/17 for a problem of self-care deficit related to limited mobility, weakness, and dialysis. The goal included the resident would remain clean dry and odor free and have his needs met through the next review. The approaches included for the nursing assistants to provide incontinence care during routine rounds and as needed in a timely manner.</p> <p>On 12/07/17 from 12:30 to 1:00 PM continuous observations of Resident #76 were made during lunch meal pass. The resident was in his bed, turned onto his right side facing the window. His back, brief and bottom sheet was observed to</p>	F 677	<p>The facility will ensure that each resident dependent on staff for care receives personal hygiene services as needed. Facility staff failed to provide incontinent care while passing meal trays related to staff education. Resident #91 did not receive two showers/ week as scheduled related to oversight.</p> <p>Resident #6 was provided incontinent care at the time of survey. Facility will interview resident #91 regarding his preference for timing of his showers. Resident #91 will receive showers based on his preference.</p> <p>SDC will educate facility staff in regards to providing residents with incontinent care as needed by 1/5/18. SDC will educate facility staff regarding providing resident showers per the shower schedule by 1/5/18.</p> <p>SDC,DON or ADON will conduct resident care audits of at least 10% of residents weekly for four weeks then monthly for twelve months that includes resident interview, observation of resident care, and documentation by 1/5/18. Immediate staff education will occur as indicated. A QI tool will be utilized.</p>		

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F 677	<p>Continued From page 18</p> <p>have loose stool and a foul odor was noticed at his doorway. Nursing Assistant (NA) #2 went into his room at 1:00 PM and provided incontinence care.</p> <p>Interview on 12/7/17 at 1:15 PM with NA #2 revealed she was aware Resident #76 had a bowel movement and it had a bad odor. She further explained she had passed trays on 100 and 200 halls first, helped in the dining room on the unit before providing incontinence care. When asked what would she be expected to do if a resident needed toileting or incontinence assistance during meal pass and she explained she should have stopped and given incontinence care to the resident. In further interview, she explained both needed to be done at the same time, and both were important.</p> <p>Interview on 12/8/17 at 9:00 AM with the Director of Nursing revealed she would expect the nursing staff to provide incontinence care first, then continue passing the meal trays.</p> <p>2. Resident #91 was re-admitted to the facility on 7/30/17 with diagnosis including stroke, dominant side hemiplegia, neurogenic bladder and diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) dated 11/9/17 indicated no impairment with short or long- term memory. Resident #91 required extensive assistance of two staff for mobility, transfers, extensive assistance of one staff for ambulation in the room and hallway, locomotion on the unit, toileting, personal hygiene and eating.</p> <p>Review of the care plan dated 7/31/17 for a</p>	F 677	Results of audits will be submitted to the monthly quality committee for review.		

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F 677	<p>Continued From page 19</p> <p>problem of self-care deficit related to stroke with hemiplegia on dominant side. The goal included the resident would remain clean, dry and odor free and have his needs met through the next review. The approaches included provide assistance with ADLs (activities of daily living) as needed, allow resident time to perform tasks at own rate and do not rush resident.</p> <p>Review of the facility assignment for the nursing assistants (NA) included the bath schedule. Resident #91 was scheduled for showers on first shift on Wednesday and Saturday.</p> <p>Review of the documentation by the NA 's of personal hygiene from 11/8/17 to 12/8/17 indicated Resident #91 received 3 showers, and 1 complete bed bath. Resident #91 refused a shower twice in a month. For the week of 12/1 to 12/8/17 he had not received any documented showers, bed baths or sponge baths.</p> <p>Interview on 12/6/17 at 9:05 AM with Resident #91 revealed he did not receive his showers as scheduled. He further explained he might have one shower a week. He did not know why it was not done.</p> <p>Interview with the Director of Nursing on 12/8/17 at 9:00 AM revealed she would expect residents to receive their showers or bed baths. She was not able to explain why Resident #91 had not received his showers/baths.</p> <p>Interview with NA#3 on 12/8/17 at 2:02 PM revealed she was assigned to the resident on 12/7/17 revealed the resident said he wanted his bath at night. She did not offer a bed bath or sponge bath. She further explained the resident</p>	F 677			

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F 677	Continued From page 20 would roll into the bathroom and wash his face and hands. During interview, she indicated she had not informed the nurse of his preference, and did not know how to document his care.	F 677			
F 688 SS=D	<p>Interview on 12/8/17 at 2:30 PM with the Nurse Supervisor revealed residents can have a bath whenever they choose. It is scheduled, but the resident can decide. She was not aware Resident #91 was not receiving his baths.</p> <p>Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide application of splints according to the restorative treatment plan for one of one sampled residents with limited range of motion (Resident #</p>	F 688	The facility provides application of splints as indicated by the resident's restorative treatment plan. The facility staff failed to provide application of splints for resident #75 because of an oversight.	1/5/18	

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F 688	<p>Continued From page 21 75).</p> <p>The findings included:</p> <p>Resident #75 was admitted to the facility on 9/2/09 with diagnosis that included a neuromuscular disorder.</p> <p>Review of the most recent Minimum Data Set (MDS) dated 10/23/17 indicated Resident #75 had some problems with short term memory and no problems with long term memory. He had a BIMs (Brief Interview for Mental Status) of 11. This MDS indicated he had functional impairment with limited movement of the upper and lower extremities.</p> <p>Review of the care plan with a problem onset dated 6/8/17 included a splint/brace to be applied due to the resident being at risk for developing further contractures to bilateral upper extremities. The approaches included restorative nursing was to apply a soft tan cock up splint to the left wrist/hand and a dorsal (black) splint to the right upper extremities daily for 4-6 hours after completing passive range of motion as tolerated, and document if resident refuses care.</p> <p>Review of the documentation by restorative nursing assistants (RNA) for the timeframe from 11/23/17 to 12/7/17 revealed the passive range of motion and splints were documented as being completed on all days except on 11/26, 11/27, 11/28, 12/3 and 12/6/17.</p> <p>Interview on 12/7/17 at 12:00 PM revealed she had provided restorative for this resident. She did active range of motion to upper extremities and passive range of motion to lower extremities. He</p>	F 688	<p>The plan of care for resident #75 as it relates to splinting will be reviewed with the restorative nursing staff by 1/5/18 . Resident #75 will have splints applied according to the resident's plan of care.</p> <p>Facility therapy manager conducted a 100% audit of residents who have splinting as a therapy recommendation.</p> <p>Facility ADON or MDS nurse will review each resident's plan of care with a recommendation for splinting with the restorative nursing team before 1/5/18.</p> <p>SDC,DON or ADON will conduct resident care audits of at least 25% of residents with splinting weekly for four weeks that includes resident interview, observation of resident care, and documentation. A QI tool will be utilized.</p> <p>Results of audits will be submitted to the monthly quality committee for review.</p>		

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

PRINTED: 01/09/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345547	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/08/2017
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F 688	Continued From page 22 had splints to both hands and wore them 6 to 8 hours every day. The resident did not refuse the splints. She did not apply them on Tuesday (12/5/17) this week, but did apply them on Monday and Wednesday. She stated sometimes she had problems finding the splints and did not know what the aides had done with them. Review of the documentation with RNA #1 revealed the splints were documented as being applied. Further interview revealed she usually applied them in the morning. RNA #1 did not have a response as to the discrepancy in the documentation, her interview and the observations that were made on 12/5 and 12/6/17. Interview with Resident #75 on 12/7/17 at 12:10 PM revealed he did not have the splints on until this am. He said he did not know why, maybe they were busy. Interview on 12/8/17 at 9:15 AM with the Director of Nursing revealed she was not aware the resident had not had the splints applied. Further interview revealed she would need to investigate and give me an answer later. The Director of Nursing did not provide an explanation and her expectation would be for the splints to be applied.	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent	F 689		1/5/18	

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F 689	<p>Continued From page 23</p> <p>accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide intervention for fall prevention for one of three sampled residents with falls. (Resident # 79).</p> <p>The findings included:</p> <p>Resident #79 was admitted to the facility on 10/3/17 with diagnosis that included stroke and dementia.</p> <p>Review of the Minimum Data Set (MDS) dated 10/10/17 indicated he had long and short- term memory problems, severe impairment with decision making abilities, had continuous problems with inattention, easily distracted and disorganized thinking. The MDS indicated he required extensive to total assistance of two staff for activities of daily living, did not ambulate and had not had a fall prior to admission.</p> <p>Review of a nurses note dated 11/5/17 revealed Resident #79 had fallen when he stood up from the wheelchair in the common area. He had no injuries and staff responded, but was unable to catch him. The care plan was updated after the fall, and anti-roll backs were added to the wheelchair. The resident was already receiving therapy.</p> <p>Observations on 12 /05/17 at 3:44 PM revealed no anti-roll backs were on the wheelchair.</p> <p>Observation of the wheelchair on 12/5/17 at 4:36 PM revealed he did not have the anti-roll backs on the wheelchair. The wheelchair was rolled by</p>	F 689	<p>The facility will provide interventions for residents with falls. The facility failed to provide anti- rollback breaks as an intervention for resident #75.</p> <p>Resident was evaluated by therapy and anti - rollback brakes were applied as recommended on 12/8/17.</p> <p>ADON and MDS nurse reviewed plans of care for 100% of residents with falls by 12/27/17.</p> <p>All residents will be observed to ensure all care plan interventions related to resident falls are being implemented for each individual resident by 12/27/17.</p> <p>ADON will review all residents who have fallen weekly for four weeks then monthly for 12 months to ensure all fall interventions are in place according to the resident's plan of care by 1/5/18. A QI tool will be utilized.</p> <p>QI tools will be submitted to the monthly quality committee for review.</p>		

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F 689	<p>Continued From page 24</p> <p>the nursing assistant back and forth without any resistance. The anti-roll backs would have prevented the wheelchair moving backwards.</p> <p>Observations on 12/7/17 at 10:25 AM Resident #79 was seated in his wheelchair in the dining area by nurse's station. No anti-roll backs were observed on the resident ' s wheelchair.</p> <p>Interview with therapy manager on 12/7/17 at 11:30 AM revealed the manager was in a meeting for falls about the resident. The therapy would check for the correct size of anti- roll backs and maintenance would apply them. It was up to nursing to ensure they were applied. During the interview, the therapy manager explained he had no knowledge if the anti-roll backs had been applied.</p> <p>Interview with the maintenance director on 12/7/17 at 1:30 PM revealed he was in the morning meeting and would have been informed at that time for the need of anti-roll backs. During the interview, the maintenance director explained he did not have a work order for the anti-roll backs, it was verbally given to him. The administrator attended this interview and explained the resident was currently in a different wheelchair, as affirmed by the maintenance director. She was not sure how or when the wheelchair was changed. The care plan was changed yesterday to have the anti-roll backs discontinued since he had not had another fall.</p> <p>Interview on 12/7/17 at 4:00 PM with a family member who visits several times each week revealed she had not seen anti-roll backs on the back of the wheels to the wheelchair. She expressed understanding of what an anti-roll back</p>	F 689			

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F 689	Continued From page 25 was and looked like. Interview with MDS nurse #2 on 12/8/17 at 9:50 AM revealed she had not attended a meeting to discuss removing the anti-roll backs from Resident #79 ' s wheelchair. Interview with NA#3 on 12/8/17 at 9:50 AM revealed Resident #79 was not supposed to transfer himself without help, but she had found him in his bed at times. She could not recall if there were anti-roll backs on the wheelchair. Interview with NA#2 on 12/8/17 at 9:55 AM revealed Resident #79 did not have anti-roll backs on his wheelchair when she had worked with him. Interview with an occupational therapist (OT) on 12/8/17 at 3:28 PM revealed she had completed an evaluation that day for Resident #79. The OT explained she had no prior knowledge of the resident and evaluated him for safety in the wheelchair. She further explained she had recommended anti-roll backs be on the wheelchair due to his impulsiveness, lack of safety awareness, apraxia and not consistent in remembering to lock the brakes on the wheelchair. During the interview, she revealed the resident would tell her he needed to lock the brakes, but would not remember where the brakes were located.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		1/5/18	

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F 690	<p>Continued From page 26</p> <p>admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interviews and observations, the facility failed to have a documented diagnosis for the continued use of an indwelling urinary catheter for 16 days, failed to assess the resident for removal of the catheter and failed to properly secure the indwelling</p>	F 690	<p>The facility reviews all residents who use an indwelling catheter to ensure the catheter is not used unless the residents clinical condition demonstrates catheterization is necessary. The facility failed to associate a diagnosis for the use</p>		

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F 690	<p>Continued From page 27</p> <p>urinary catheter for 3 of 4 sampled residents reviewed for indwelling catheters. (Residents #274, 327 and 79).</p> <p>1. Resident #274 was admitted to the facility on 11/10/17 with the current diagnosis of wounds to lower extremities, diabetes, hypertension and anemia.</p> <p>Resident #274 had a care plan in place created on 11/29/17 for an indwelling catheter related to the inability to empty his bladder. Interventions included that the resident had a tubing secured to thigh to prevent pulling and evaluate for the removal of catheter.</p> <p>Resident #274's admission Minimum Data Set (MDS) dated 11/24/17 revealed he was cognitively intact. Resident #274 required extensive assistance with bed mobility, toilet use and personal hygiene. The resident had an indwelling catheter and was occasionally incontinent of bowel.</p> <p>1A. A Physician's telephone order from the on-call Physician dated 11/20/17 stated for an in and out urine catheterization to be completed and if more than 350 milliliters of urine was obtain then leave catheter in. The order was signed by Resident #274's attending Physician on 11/22/17.</p> <p>Resident #274's November 2017 Medication Administration Record (MAR) included an order dated 11/20/17 to perform an in and out catheterization and if urine output is greater than 350 ml, leave catheter in place. This was completed on 11/20/17 at 9:30 PM.</p> <p>A nursing note written by Nurse #4 dated 11/21/17 stated Resident #274 had a condom</p>	F 690	<p>of a catheter for 16 days. The facility failed to properly secure the catheters for resident #274, #327 and # 79.</p> <p>A clarification order for the use of the catheter for resident #274 was written 12/5/17. Resident's catheter was discontinued 12/11/17.</p> <p>Securement devices for the catheters for residents #274, #327, and #79 were applied on 12/11/17.</p> <p>Licensed nursing staff will be inserviced regarding the requirement to have a supporting diagnosis for ongoing catheter use.</p> <p>All residents who currently use catheters were reviewed by facility SDC to ensue a supporting diagnosis is associated with the use of the catheter. A securement device was applied for all residents who use a Foley catheter as indicated by the residents plan of care.</p> <p>ADON, DON or SDC will conduct care observations of residents with catheters weekly to ensure residents with catheters have a supporting diagnosis for their use and securement devices are in place as indicated. A QI audit tool will be utilized.</p> <p>Results of audits will be submitted to the monthly quality committee for review for three months.</p>		

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F 690	<p>Continued From page 28</p> <p>catheter in place and was unable to void for 6 hours this shift. The on-call provider was contacted and an in and out catheterization was performed with 400 ml of urine obtained. A size 14 French catheter was left in place and the procedure was tolerated well. The Resident was also started on antibiotic treatment for a Urinary Tract Infection (UTI).</p> <p>Further review of the Resident #274's medical record from 11/21/17 through 12/6/17 revealed that Resident #274 did not have a documented diagnosis/rationale by the physician for his indwelling urinary catheter.</p> <p>The Physician's note dated 12/5/17 revealed that on 11/16/17, Resident #274 had a urinalysis completed and had a Urinary Tract Infection with Methicillin Resistant Staphylococcus Aureus and was started on antibiotics. The note also stated that the Resident had a condom catheter and a history of bowel incontinence for a year. The Physician's note did not indicate that Resident #274 had an indwelling urinary catheter inserted on 11/20/17.</p> <p>Resident #274 was interviewed on 12/7/17 at 3:48 PM. He stated he had his urinary catheter in for 3 weeks and has not had any issues with it. He had it placed because of the wound on his buttock. He stated that he didn't have any problems or infections with his urinary catheter.</p> <p>An interview was conducted with Physician on 12/8/17 at 11:06 AM. She stated that Resident #274 had a condom urinary catheter in place for his comfort status since his admission. She stated that after reviewing the resident's chart on 11/21/17, the resident was unable to void and an</p>	F 690			

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F 690	<p>Continued From page 29</p> <p>in and out urinary catheter was ordered and the on call provider asked to keep the catheter in place. She would expect that staff would report it to her if a resident had an indwelling urinary catheter placed. She stated that she did not know that Resident #274 had an indwelling urinary catheter in place and was just informed of this today.</p> <p>Nurse #4 was interviewed on 12/7/17 at 4:14 PM. She stated that the Resident #274 initially had a condom catheter and was unable to void on 11/20/17 and an in and out urinary catheter was ordered. However, she got 400 ml out and the physician placed an order to leave in an indwelling catheter. Resident #274 would say he "couldn't go to the bathroom." Nurse #4 further stated the Resident #274 had not had any problems with his urinary catheter and had not had an UTI since then.</p> <p>Nurse #5 was interviewed on 12/8/17 at 12:20 PM. She stated she was not really sure why Resident #274 had the urinary catheter. Nurse #5 explained there was a physician communication book that they would write any new concerns in and if the on call physician was notified of an issue. She stated that if a resident got a urinary catheter placed by the on call physician then she would put it in the provider's communication book or in the 24 hour report so that everyone was aware of it.</p> <p>The Nurse Consultant was interviewed with the Administrator present on 12/8/17 at 2:30 PM. She stated that residents are were reviewed on admission for catheter usage and they made sure residents had a justification of the use of a urinary catheter and if the physician initiates the order for</p>	F 690			

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F 690	<p>Continued From page 30</p> <p>a catheter then they would go back to the physician for an appropriate diagnosis for the urinary catheter. Also, the Quality Assurance Committee would evaluate the urinary catheters to ensure they have had a supporting diagnosis and appropriate use of the catheter. She stated they did have a justification of use for the catheter as the resident was unable to void on 11/20/17 and Resident #274 was reviewed for it (no specific information as to what was reviewed was stated). She stated that on 12/6/17, there was an order placed to maintain Resident #274's urinary catheter to promote wound healing.</p> <p>1B. Resident #274 was interviewed on 12/7/17 at 3:48 PM. He stated he had the indwelling urinary catheter for 3 weeks and had not had any issues with it. He stated that the catheter tubing did not have a securing device attached to it or to his leg.</p> <p>An observation was made with the wound care nurse on 12/7/17 at 3:54 PM. Resident #274 indwelling urinary catheter tubing was observed and was not secured to the resident's leg or have a securing device attached to it.</p> <p>Another observation was made of Resident #274's urinary catheter on 12/8/17 at 9:48 AM with the Wound Care Nurse. Resident #274 urinary catheter did not have securing device in place and the resident was turned on his side during wound care.</p> <p>Nurse #5, who was caring for the resident, was interviewed on 12/8/17 at 12:20 PM. The securing device was separate from the kit they used to insert the urinary catheter with. She stated that any staff member can put the securing urinary device on the resident and that Resident #274's</p>	F 690			

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F 690	<p>Continued From page 31 may have come off.</p> <p>The Wound Care Nurse was interviewed on 12/8/17 at 10:05 AM. She stated that she was not sure why Resident #274 did not have a urinary catheter securing device in place and that he should have one.</p> <p>The Nurse Consultant was interviewed with the Administrator present on 12/8/17 at 2:30 PM. She stated that she would expect that the urinary catheter was secured to prevent injury.</p> <p>2. Resident #79 was admitted to the facility on 10/3/17 with diagnoses that included stroke and enlarged prostate.</p> <p>Record review revealed no orders on admission for the use of the urinary catheter. Record review revealed no orders to remove the urinary catheter. There were no nurses' notes for review regarding an assessment for the use or removal of the urinary catheter.</p> <p>Review of the care plan dated 10/4/17 included a problem for use of an indwelling catheter. The goal included the resident would experience no infections from catheter use through next review. The approaches for this problem included nursing would evaluate for removal of the catheter.</p> <p>Review of the Minimum Data Set (MDS), an admission, dated 10/10/17 indicated Resident #79 had an indwelling urinary catheter. This MDS assessed the resident as having long and short term memory impairment.</p>	F 690			

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F 690	Continued From page 32 Observations on 12/5/17 at 3:35 PM revealed Resident #79 did not have an indwelling urinary catheter. Interview with the supervisor nurse on 12/6/17 at 1:00 PM revealed the resident did not have an indwelling urinary catheter. Further interview revealed he did not have an order in the discharge summary from the hospital for the urinary catheter. Review of the admission orders with the supervisor nurse revealed he did not have an order for the urinary catheter and he did not have an order to remove the catheter. The nursing admission note included the resident had an indwelling urinary catheter on the admission assessment. Review of the nurses' notes revealed no documentation when the indwelling urinary catheter was removed, or assessments for bladder function after removal. Interview with the Director of Nursing on 12/8/17 at 9:05 AM revealed the admission nurse would have been responsible for obtaining orders for the use of the catheter. An order would have been needed to remove the urinary catheter. She would expect the nurses to obtain orders before continuing or removing the catheter.	F 690			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		1/5/18	

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F 756	<p>Continued From page 33 of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff and consulting pharmacist interviews and record review the facility failed to complete an abnormal involuntary movement assessment for Resident #79 and failed to act on the consultant recommendations to nursing for Residents #79 and 75 for two of five sampled</p>	F 756	The facility reviews the recommendations of the consultant pharmacist and takes actions based on the pharmacist's recommendations. Monthly pharmacy recommendations are addressed by the physician and DON or designee within ten		

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F 756	<p>Continued From page 34 residents for unnecessary medications</p> <p>The findings included:</p> <p>1. Resident #79 was admitted to the facility on 10/3/17 with diagnosis that included stroke and dementia.</p> <p>Review of the physician orders revealed he received Seroquel (antipsychotic) every evening.</p> <p>Review of the assessments revealed no assessment for the abnormal involuntary movement (AIMs) for possible side effects from the drug.</p> <p>Interview with the nurse supervisor on 12/7/17 at 10:40 AM revealed the MDS nurse made the schedule for the AIMs. The AIMs were done quarterly. If a resident was admitted on an antipsychotic medication, an AIMS would be completed on admission.</p> <p>Interview with the Director of Nursing on 12/8/17 at 9:50 AM an AIMs should have been completed on admission. The nurse on the floor would do the assessment. The pharmacy reports were divided among the nurses and the recommendations would be assigned. Further interview revealed she would check as to why the AIMs was not completed.</p> <p>Interview with the consulting pharmacist on 12/8/17 at 10:20 AM revealed a recommendation was made to nursing on 11/7/17 and again on 12/5/17 for the AIMs to be completed.</p> <p>2. Resident #75 was admitted to the facility on 7/1/09 with diagnosis that included</p>	F 756	<p>days of receiving the report. The facility failed to act on the pharmacist's recommendations for resident #79 and resident #75.</p> <p>AIMS for resident #79 will be completed by 12/18/17. Allergies for resident #75 will updated on the resident's MAR by 1/5/18.</p> <p>Facility DON, SDC and ADON will audit the consultant pharmacist's recommendations completed in the last 60 days to ensure 100% of recommendation have been acted upon by 1/5/18.</p> <p>DON will monitor completion of 100% of pharmacy consultant recommendations monthly for 3 months.</p> <p>DON will submit completed audit of pharmacy recommendations to the monthly QA committee monthly for three months.</p>		

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F 756	Continued From page 35 neuromuscular disorder. Review of the history and physical dated 7/1/09 included a list of allergies. The allergies were to Penicillins, Betalactams, Penicillamine, Beta Lactams, Carbapenems and Cephalosporins. Review of the consulting pharmacist monthly reports revealed irregularities for nursing were identified on 8/8/17 and again on 12/5/17. Review of the monthly physician orders and monthly Medication Administration Records did not include all of the allergies. Interview with the consulting pharmacists on 12/8/17 at 10:20 AM revealed a recommendation had been made on 8/8/17 and again on 12/5/17. The report had not been acted upon. Review of the Medication Administration Record for November and December 2017 revealed the allergies had not been updated. Interview with the Director of Nursing on 12/8/17 at 9:50 AM revealed the consultant pharmacist report was divided among the nurses and the recommendations were assigned. An explanation was not provided as to why the consultant pharmacy report had not been acted upon.	F 756			
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F 808		1/5/18	

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F 808	<p>Continued From page 36</p> <p>§483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff and resident interviews and record review the facility failed to provide a therapeutic diet of liberal renal for one of two sampled residents receiving hemodialysis. Resident #368.</p> <p>The findings included:</p> <p>Resident #368 was admitted to the facility on 10/26/17 with a diagnosis that included end stage renal disease with dialysis treatment.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 11/2/17 indicated Resident #368 had not long or short- term memory impairment. This MDS indicated the resident was on a therapeutic diet.</p> <p>Review of the admission orders dated 10/26/17 included an order for a liberal renal diet. Observations on 12/6/17 at 12:31 PM revealed she received bar-b-que pork chop and greens on her plate. Interview with Resident #368 at that time revealed she was not supposed to have the greens due to being on dialysis.</p> <p>Interview with the Registered Dietician on 12/7/17 at 3:25 PM revealed the resident did not receive a liberal renal diet when the pork chop and greens were served. She would have received more sodium with the Bar B Cue and phosphorus with the greens.</p>	F 808	<p>The facility ensures resident's receive therapeutic diets as ordered. Diets orders are prescribed by the physician and communicated to the dietary staff. Dietary staff is responsible for providing meals as prescribed by the physician. The dietary staff failed to provided a liberal renal diet for resident #368 because of an oversight.</p> <p>Resident #368 has discharged from the facility.</p> <p>The dietary manger will complete a 100% audit of resident diet orders to ensure each resident's diet card is accurate according to the physician order by 1/5/17.</p> <p>Dietary staff will be inserviced regarding tray card accuracy including the parameters for residents on a liberal renal diet.</p> <p>Dietary manager will monitor 10% of trays delivered three times weekly for accuracy. A QI tool will be utilized.</p> <p>Results of audits will be submitted to the quality committee monthly for review.</p>		

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PRINTED: 01/09/2018
FORM APPROVED
OMB NO. 0938-0391

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F 808	Continued From page 37	F 808			
F 812 SS=F	<p>Interview with the dietary manager on 12/7/17 at 3:50 PM revealed Resident #368 was on a liberalized renal diet. The cook was responsible for ensuring the residents received the correct diet. He did not know what happened for the resident to receive the greens and bar b cue pork chop. He explained that was not on her diet.</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, residents and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; by failing to store food items separately from non-food items and not on the floor; by not ensuring dishes were</p>	F 812	<p>The facility is responsible for ensuring food is served under sanitary conditions. The facility staff failed to ensure resealed items were labeled and dated; food items were stored separately from non food items and not stored on the floor; dishes</p>	1/5/18	

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F 812	<p>Continued From page 38</p> <p>stacked clean on the food service tray line; and, by not ensuring food supply storage and preparation areas were maintained clean, free from debris and free from staff clothing. The facility also failed to maintain sandwiches at acceptable temperatures of 41 degrees Fahrenheit or below during 1 of 1 meal tray line service observation.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During the initial tour of the kitchen with the DM (Dietary Manager) on 12/4/17 at 3:02pm, the walk-in refrigerator contained opened/resealed 4-five pound containers of salad spreads (tuna salad, chicken salad, egg salad, and pimento cheese) that were not dated when opened. The DM stated the dietary staff only refer to the "use by" date on the containers. The dry food storage room consisted of 1-resealed bag of seafood batter, 1-resealed bag of macaroni noodles, and 1-resealed bag of sugar that were also not dated when opened. 2. During the observation of the walk-in freezer on 12/4/17 at 3:05pm, there were eight cases of food items stored on the floor beneath the shelves. 3. Observation of the dry food/supply storage room on 12/4/17 at 3:10pm revealed racks of bread loaves stored next to paper cups, foil, and aluminum pans. There was an employee's cap and three jackets stored on one of the storage racks next to cases of plastic cups. 	F 812	<p>were stacked clean on the food service tray line; and food storage areas were maintained clean, free from debris and free of staff clothing. The facility failed to maintain sandwiches at an acceptable of 41degrees Fahrenheit or below during one meal service observation. These areas were not in compliance due to lack of staff training.</p> <p>The dietary manager discarded the salad spreads that were not dated when opened on 12/5/17. The dietary manager discarded the seafood batter, macaroni noodles and sugar that was not dated when opened on 12/5/17.</p> <p>The food items in the freezer that were stored on the floor in the walk-in freezer on 12/4/17 was relocated to appropriate shelving on 12/5/17.</p> <p>The racks of bread loaves that were stored next to non food items were relocated as to not be next to non food items on 12/22/17. The employee items stored in the storage room were relocated and an adequate area for storing personal items was provided on 12/22/17.</p> <p>The flour and sugar bins were cleaned 12/22/17. The brooms stored with heads down are properly stored as of 12/22/17.</p> <p>The floor drain beneath the supply sinks and the preparation sinks will be replaced by 1/5/18.</p> <p>All nourishment rooms were cleaned on</p>		

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F 812	<p>Continued From page 39</p> <p>4. On 12/4/17 at 3:41pm, the lids of the sugar bin and the flour bins were sticky to touch and stained with light brown residue. There were three brooms stored with the heads down, touching the floor and leaning against the walls in the mop/chemical room.</p> <p>On 12/7/17 at 12:45pm, the grid of the floor drain beneath the supply sink was haphazardly propped in the drain and the drain was stained with a yellow/brown substance. The floor drain beneath the preparation sink was missing half of the grid covering. The dietary cook indicated the dietary staff failed to follow the posted cleaning schedule.</p> <p>Observations of 2 of 4 nourishment rooms on 12/7/17 at 2:02pm, revealed dried, sticky, red/brown spots on the cabinet's counter-space. The inside of the microwave ovens were stained w/brown substances. The DM stated that the facility's housekeeping staff were responsible for cleaning the nourishment rooms.</p> <p>5a. During the meal tray line service observation in the kitchen on 12/7/17 at 11:38am, there were multiple, individually wrapped sandwiches on a large sheet pan in an opened-sided cart next to the meal preparation line. The temperatures of the egg salad, tuna, chicken salad, and pimento cheese sandwiches ranged from 56 degrees Fahrenheit to 58.5 degrees Fahrenheit. The dietary cook revealed the sandwiches were for residents who requested them and stated that the sandwiches were to remain in the walk-in refrigerator until needed. The dietary cook instructed the staff to remove the pan of</p>	F 812	<p>12/7/17 to eliminate the stick substance on the cabinets counter space and stains inside the microwave. The microwaves that are permanently stained will be replaced by 1/5/18.</p> <p>The sandwiches observed not to be at proper serving temperature at the time of survey were discarded.</p> <p>The six divided plates, two regular plates and four small saucers were taken off the tray line at the time of the survey.</p> <p>Dietary manager will inservice dietary staff regarding the facility policy for labeling and dating resealed items and proper storage of food items by 1/5/18.</p> <p>Dietary manager will inservice dietary staff regarding safe food handling to include proper serving temperatures for food items by 1/5/18.</p> <p>Dietary manager will inservice dietary staff on the process to ensure eating utensils are clean by 1/5/18.</p> <p>Dietary manager will inservice dietary staff regarding cleaning schedules for the kitchen to include the floor drains, flour and sugar bins and the proper storage of cleaning equipment by 1/5/18.</p> <p>Administrator will update the cleaning schedule for the nourishment rooms to include the microwave and counters by 1/5/18. Administrator will educate the housekeeping staff regarding the cleaning</p>		

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F 812	Continued From page 40 sandwiches from the tray line and obtain one of the prepared sandwiches from the refrigerator, if needed during this meal service. 5b. There were 6-divided plates, 2-plates, and 4-small saucers stained with dried, brown and yellow substances, stacked and ready for use by the dietary cook on the meal tray line in the kitchen.	F 812	schedule for the nourishment rooms by 1/5/18. Dietary manager will complete sanitation rounds in the kitchen and nourishment rooms that address appropriate food storage, safe serving temperatures, cleanliness of stored eating utensils, and adherence to cleaning schedules five times weekly for four weeks. A QI tool will be utilized. Results of audits will be submitted to the monthly quality assurance committee for review.		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		1/5/18	

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F 865	<p>Continued From page 41</p> <p>Based on observations, record reviews, resident and staff interviews, the facility's Quality Assurance and Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor these interventions that the committee put into place October 2016 and August 2017. This was for two (2) recited deficiencies. One deficiency F312 was originally cited on 10/14/16 during a recertification survey, and again on 12/8/17 recertification and the second deficiency F323, originally cited on 8/2/17 during a complaint survey and again on 12/8/17 during a recertification survey. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality of Assurance and Performance Improvement Program.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>1. F677. Care to dependent residents. Based on observations, resident and staff interviews and record review the facility failed to provide personal hygiene for 2 of 4 sampled residents dependent on staff for care. Resident # 76 did not receive incontinent care and Resident #91 did not receive weekly scheduled showers.</p> <p>Recertification survey of 10/14/16, F 312, the facility failed to provide morning care and incontinence care to dependent resident. (Resident #38).</p> <p>2. F 689 Supervision to prevent accidents. Based on observations, staff interviews and record review the facility failed to provide intervention for fall prevention for one of three sampled residents</p>	F 865	<p>The facility will ensure that each resident dependent on staff for care receives personal hygiene services as needed. The previous system for monitoring ADL care included managers making rounds three times weekly and submitting those rounds to the administrator.</p> <p>The facility will ensure the interventions are in place to prevent repeated falls for residents. The previous plan did not include an audit tool for routine resident observations for care planned interventions by ADON.</p> <p>Modifications to the QA program will be implemented as follows by 1/5/18.</p> <p>The facility will ensure that each resident dependent on staff for care receives personal hygiene services as needed. Facility staff failed to provide incontinent care while passing meal trays. Resident #91 did not receive two showers/ week as scheduled.</p> <p>Resident #6 will be provided incontinent care as needed. Facility will interview resident #91 regarding his preference for timing of his showers Resident #91 will receive showers based on his preference.</p> <p>SDC will educate facility staff in regards to providing residents with incontinent care as needed by 1/5/18. SDC will educate facility staff regarding providing resident showers based on the shower schedule by 1/5/18.</p>		

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F 865	Continued From page 42 with falls. (Resident # 79). Complaint survey of 8/2/17, F323, the facility failed to have interventions to prevent repeated falls for sampled resident. (Resident #4) Interview on 12/8/17 at 1:41 PM revealed the facility holds QAPI meetings and reviews falls, activity of daily living (ADLs), weight and pressure ulcers on a regular basis. The current system included managers making rounds 3 times a week on all residents for problems with ADL provision. The round report is submitted to the administrator. Accident/incidents are reviewed in the morning meeting with the IDT for interventions. The Assistant Director of Nursing was responsible to ensure interventions were in place.	F 865	SDC,DON or ADON will conduct resident care audits of at least 10% of residents weekly for four weeks then monthly for twelve months that includes resident interview, observation of resident care, and documentation by 1/5/18. Immediate staff education will occur as indicated. A QI tool will be utilized. Results of audits will be submitted to the monthly quality committee for review for three months. The facility will provide interventions for residents with falls. The facility failed to provide anti- rollback breaks as an intervention for resident #75. Resident was evaluated by therapy and anti - rollback brakes were applied as recommended on 12/8/17. ADON and MDS nurse reviewed plans of care for 100% of residents with falls by 12/27/17. All residents will be observed to ensure all care plan interventions related to resident falls are being implemented for each individual resident with falls by 12/27/17. ADON will review all residents who have fallen weekly for four weeks then monthly for 12 months to ensure all fall interventions are in place according to the resident's plan of care by 1/5/18. A QI tool will be utilized. QI tools will be submitted to the monthly		

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F 865	Continued From page 43	F 865	quality committee for review for three months. The quality committee will revise the plan as indicated.		