

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

PRINTED: 02/12/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2018
NAME OF PROVIDER OR SUPPLIER PREMIER LIVING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 106 CAMERON STREET LAKE WACCAMAW, NC 28450		
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F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care</p>	F 656		2/8/18	

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

TITLE

(X6) DATE

Electronically Signed

02/08/2018

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 656	<p>Continued From page 1</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interviews the facility failed to develop a comprehensive Care Plan for 1 of 1 Residents (Resident #89) investigated for catheters and failed to develop a comprehensive Care Plan for 1 of 1 Residents (Resident #44) investigated for Hospice. Findings included:</p> <p>1. Review of the Quarterly Minimum Data Set dated 12/24/17 revealed Resident #89 was readmitted to the facility on 12/18/17 with diagnoses of functional quadriplegia, diabetes and cerebrovascular accident (CVA). Resident #89 had an indwelling catheter.</p> <p>Review of Resident #89's Care Plans which had been updated on 01/09/18 revealed no Care Plan for an indwelling catheter.</p> <p>In an observation on 01/10/18 at 9:45 AM Resident #89 was lying in bed. An indwelling catheter was in place to bedside drainage.</p> <p>In an observation on 01/10/18 at 2:02 PM Resident #89 was lying in bed. The indwelling catheter was in place to bedside drainage.</p> <p>In an interview on 01/12/18 at 1:51 PM MDS Nurse #1 stated a catheter Care Plan should be developed right away and not left to be done quarterly. She indicated her assistant had been responsible for Resident #89's Care Plan and she did not know why Resident #89's catheter Care Plan was not developed. She stated her</p>	F 656	<p>Resident #89's Care Plan was reviewed and updated to include the indwelling catheter on 1/11/18.</p> <p>Resident's #44's Care Plan was reviewed and updated to include Hospice services on 1/12/18.</p> <p>All Care Plans for all other residents with indwelling catheters and under hospice services were reviewed to ensure that they are complete and accurate.</p> <p>All new orders will be reviewed daily (M-F) by administrative nursing personnel to ensure appropriate care plans are initiated. Additionally, the MDS Resident Matrix will be reviewed daily (M-F) by administrative nursing personnel in order to ensure all special services are identified and care planned.</p> <p>The Interdisciplinary Team (IDT) was in serviced on the importance of having comprehensive care plans for all special services provided for residents.</p> <p>The Social Worker or designee will perform weekly audits to confirm that hospice services are included on resident care plans x's 4 weeks.</p> <p>Infection Preventionist or designee will perform weekly audits to confirm that</p>		

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F 656	<p>Continued From page 2</p> <p>assistant was not available but it was her expectation that the MDS and Care Plans be developed and updated as necessary.</p> <p>In an interview with the Administrator and Acting Director of Nursing on 01/12/18 at 2:35 PM they indicated they expected a catheter Care Plan to be developed when a resident had a catheter.</p> <p>2. Resident #44 was admitted to the facility on 03/30/12. Her documented diagnoses included dementia without behavioral disturbances, stage IV chronic kidney disease, chronic ischemic heart disease, and cerebrovascular accident with hemiplegia and hemiparesis.</p> <p>The resident's 11/17/17 significant change minimum data set (MDS) documented Resident #44's cognition was severely impaired, she required extensive assistance from staff to being dependent on staff for her activities of daily living (ADL's), and she was receiving hospice services.</p> <p>A 11/20/17 significant change progress note documented, "Significant change is due to receiving services from _____ (name of hospice organization) on 11/12/17."</p> <p>A review of Resident #44's current plan revealed it did not address the provision of hospice services for the resident.</p> <p>During an interview with MDS Coordinator on 01/12/18 at 2:02 PM she stated care plans were developed and updated quarterly. She added that the care plans were also to be updated in</p>	F 656	<p>indwelling catheters are included on resident care plans x's 4 weeks.</p> <p>Audit results will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 656	Continued From page 3 between quarterly reviews if there were significant changes in the resident's cognitive and/or physical status and care and/or service requirements. She explained when a resident began hospice services, a significant change MDS was developed, the provision of hospice services was documented in Section O of the MDS, and a hospice care plan was developed by the facility. After reviewing Resident #44's care plan, the MDS Coordinator stated it did not address the provision of the resident's hospice services. However, she reported the facility's care plan for the resident should have included hospice, but she was unable to explain how the provision of hospice services was overlooked. During an interview with the Acting Director of Nursing (DON) on 01/12/18 at 11:55 AM she stated she thought the facility was not required to develop its own hospice care plans since the hospice organizations which followed the hospice residents developed care plans which were available to the facility.	F 656			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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 §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.	F 688		2/8/18	

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F 688	Continued From page 4 §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 observation, record review and staff interviews the facility failed to provide splinting services for contracture management for 1 of 1 Residents (Resident #89) whose mobility was reviewed. Findings included: Review of Resident #89's Quarterly Minimum Data Set (MDS) dated 12/24/17 revealed Resident #89 had been readmitted to the facility on 12/18/17 with diagnoses of Cerebrovascular accident (CVA), functional quadriplegia, and stiffness of joints. Res #89 was dependent on staff for bed mobility, dressing, eating and hygiene and had functional limitations in Range of Motion (ROM) on both the upper and lower extremities. Review of the Medical Record revealed Resident #89 had been discharged to the hospital on 11/14/17 and had been readmitted on 11/28/17. Resident #89 had also been discharged to the hospital on 12/01/17 and readmitted on 12/18/17. Review of the RNA (Restorative Nursing Assistant) Progress Report with an effective date of 11/04/17 revealed under Progress Report Weeks 1 and 2 that Resident #89 received Passive Range of Motion (PROM) and splinting services. Under the Licensed Nurse Evaluation it was noted that Resident #89 had been admitted to the hospital on 11/14/17. There were no other	F 688	Resident #89 has been screened for contracture management. OT recommendations have been made, Dr.'s order obtained and ADL Care Plan updated to reflect interventions to minimize decrease in mobility. 100% audit of all residents was performed for splints, braces and appliances to ensure accurate orders and appropriate care plans for all assistive devices. Resident admission, readmissions and quarterly screens by licensed therapists will be performed to evaluate for range of motion (ROM) and potential for decrease in mobility. If a resident is identified to have limited range of motion, appropriate treatment orders will be initiated and care plan updated as indicated. Screens will be forwarded to the Interdisciplinary Team to ensure 100% of all residents are reviewed and those identified to have limited mobility receive appropriate services, equipment and assistance to maintain or improve mobility. Care Plan Coordinator will monitor for 100% compliance and report any		

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F 688	<p>Continued From page 5</p> <p>RNA Progress Reports in the medical record.</p> <p>Review of the undated Care Guide revealed an admission date of 12/18/17 for Resident #89. Under mobility was listed "Resident to wear bilateral elbow splints and bilateral functional hand splints as tolerated. Restorative nursing to apply and remove."</p> <p>Review of the Care Plan which was initiated 04/13/15 and updated 01/09/18 revealed Resident #89 had contractures to the extremities. Interventions included the wearing of bilateral elbow splints and bilateral functional hand splints as tolerated. The splints were to be applied and removed by Restorative Nursing.</p> <p>In an observation on 01/09/18 at 12:03 PM Resident #89 was lying in bed. No hand or elbow splints were in place.</p> <p>In an observation on 01/09/18 at 4:56 PM Resident #89 was lying in bed. No hand or elbow splints were in place.</p> <p>In an observation on 01/10/18 at 9:45 AM Resident #89 was lying in bed. No hand or elbow splints were in place.</p> <p>In an observation on 01/10/18 at 2:02 PM Resident #89 was lying in bed. No hand or elbow splints were in place.</p> <p>In an interview on 01/11/18 at 10:14 AM the RNA stated she had not been applying splints to Resident #89's extremities since he returned to the facility following his 11/14/17 hospitalization. She indicated she did not feel the splints were beneficial so she stopped applying them a couple</p>	F 688	omissions to the Rehab Director for immediate remediation. Care Plan Coordinator will report to QAPI on system compliance.		

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F 688	<p>Continued From page 6</p> <p>of months ago. The RNA stated Resident #89 had been automatically discharged from Restorative Nursing when he was hospitalized on 11/14/17 and she did not put him back on Restorative services on his return or ask anyone if services should be continued.</p> <p>In an interview on 01/12/18 at 10:43 AM the Rehabilitation Director, who stated she had been at the facility for approximately 1 year, indicated Resident #89 had never worn elbow splints that she was aware of. She indicated Resident #89 had been provided with resting hand splints. The Rehabilitation Director stated resting hand splints were used to prevent hands from contracting into fists, to prevent hygiene and odor issues, and to prevent skin issues that could be caused by fingernails cutting into the hand. She stated that when Resident #89 returned from the 11/14/17 hospitalization the RNA should have placed him back on services and continued with the restorative program. The Rehabilitation Director stated Resident #89 should be wearing the resting hand splints to prevent further contracture of the hands. She indicated there had been no quantitative measurements on Resident #89's initial evaluation so she was unable to tell if the contractures had worsened. She stated she was not aware Resident #89 had not been placed back on restorative services for splinting.</p> <p>In an observation and interview on 01/12/18 at approximately 11:10 AM the Rehabilitation Director accompanied the surveyor to Resident #89's room. The Rehabilitation Director manipulated Resident #89's hands and was able to partially open them. She stated resting hand splints should definitely be used to help prevent further contractures of Resident #89's hands.</p>	F 688			

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F 688	Continued From page 7 She indicated a physician order was not needed for splinting. In an interview with the Administrator and Acting Director of Nursing on 01/12/18 at 2:35 PM it was stated that if a resident was receiving Restorative Nursing services and was discharged to the hospital, it was expected that the RNA would do an assessment of the resident on readmission to see if services were still appropriate. It was expected that the RNA would discuss the resident with the nurses and therapists so that contractures could continue to be managed.	F 688			
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 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. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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	F 690		2/8/18	

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F 690	<p>Continued From page 8</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 and staff interviews the facility failed to follow-up on a urine culture which caused a delay in treatment for 1 of 1 sampled residents (Resident #89) whose records were reviewed. Findings included:</p> <p>Review of Resident #89's Quarterly Minimum Data Set (MDS) dated 12/24/17 revealed Resident #89 had been readmitted to the facility on 12/18/17 with diagnoses of Cerebrovascular accident (CVA), functional quadriplegia, and congestive heart failure. Resident #89 required the extensive assistance of two staff members for toileting needs and had an indwelling urinary catheter.</p> <p>Review of Resident #89's urology consult signed by the Family Nurse Practitioner (FNP) on 12/27/17 revealed the indwelling urinary catheter had been changed that day and a urine culture and cytology was sent from the physician's office for testing.</p> <p>Review of the laboratory Final Report of the Urine Culture that was sent from the physician's office</p>	F 690	<p>Orders for resident #89's catheter, along with diagnosis, were obtained and written on 1/11/18. Culture was reviewed to ensure bacteria causing infection was susceptible to current antibiotic treatment.</p> <p>Orders were reviewed for all other residents with indwelling catheters to ensure appropriate orders were in place.</p> <p>A new system for reviewing consults has been implemented and nursing staff will be in-serviced on new process for residents who receive consults from outside physicians and clinics. Nurses were in serviced on new process of noting provider consults.</p> <p>The DON or designee will review/audit 20% of residents on the monthly appointment calendar for 3 months, who were seen by outside physician or clinic to validate all consults were followed through per new process, care plans were updated and all orders were initiated in a</p>		

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F 690	<p>Continued From page 9</p> <p>on 12/27/17 revealed a result of Pseudomonas aeruginosa at a greater than 100,000 CFU/mL (colony-forming unit per milliliter) with a date of 12/27/17-12/29/17 (indicating the days of growth).</p> <p>Review of the prescription written by the physician on 01/02/18 revealed an order for Cipro 500mg (milligrams) by mouth every 12 hours for 10 days.</p> <p>Review of the 01/02/18 Medication Administration Record revealed the Cipro 500mg which was ordered for a urinary tract infection (UTI) was started that day at 11:30 PM.</p> <p>In an interview on 01/11/18 at 1:02 PM the Acting Director of Nursing stated the former Staff Development Coordinator (SDC) would have been responsible for following up on a culture that was sent from a physician's office to the laboratory. She indicated there should have been contact with the physician's office or laboratory after 2-3 days to find out the result of the urine culture. She stated the physician's office called them 7 days after the culture had been sent with a new order for an antibiotic to treat Resident #89's positive urine culture.</p> <p>In a telephone interview on 01/11/18 at 5:20 PM the former SDC stated when a resident was sent out of the facility for a consult, on their return, the nurse who received the resident back would read the consult notes, transcribe any orders, and inform the appropriate staff of the information on the consult. If a culture of some kind was done in a physician's office the nurse who received the consult note back would note that a culture had been sent and then inform the former SDC. He indicated he was typically the person who would follow-up on cultures sent from physician offices</p>	F 690	<p>timely manner.</p> <p>Review/audit results will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 690	<p>Continued From page 10</p> <p>but that he had not been informed a culture had been sent so no follow-up had been done. The former SDC indicated that Resident #89's antibiotic treatment was not started until 7 days after the culture had been sent and that usually cultures only took 2-3 days for results. He stated he felt the information regarding the urine culture being sent from the physician's office was just missed but that it did cause a delay in treatment.</p> <p>In a telephone interview on 01/12/18 at 1:25 PM Nurse #5, who addressed #1 and #3 of 4 recommendation/orders sent by the consulting physician, stated she did not know if she had received the consult. She stated if a consult was received the orders would be transcribed, follow-up would be done, laboratory tests would be ordered, and pharmacy would be notified. She indicated she did not tell anyone about the pending urine culture because she was unsure if she had even seen the consult sheet. Nurse #5 stated the Infection Control Nurse should have been notified of the pending culture and that a progress note should have been written.</p> <p>In an interview on 01/12/18 at 1:35 PM Nurse #6 stated that the person who received a consult should make a note, transcribe any orders to the Medication Administration Record or Treatment Administration Record, and follow-up on any radiology or laboratory tests done in the physician's office. She indicated there had been a delay in treatment for Resident #89's UTI because a follow-up was not done on the urine culture results.</p> <p>In an interview on 01/12/18 at 2:35 PM with the Administrator and Acting Director of Nursing it was stated that it was their expectation that</p>	F 690			

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(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 690	Continued From page 11 cultures done in physician offices be followed up on within 3-4 days. They indicated there had been a delay in Resident #89 receiving antibiotic treatment for a UTI.	F 690			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to restrict the fluid intake as ordered by the physician for 1 of 1 sampled residents with a physician order for a fluid restriction (Resident #18). Findings included: Resident #18 was admitted to the facility on 07/02/14. The resident's diagnoses included	F 692	CDM interviewed resident #18 on 1/11/18 and discussed the fluid restriction and how different foods (i.e., soup) count as part of fluid intake. Resident verbalizes understanding and diet was adjusted. There was a 100% audit of all other residents and no others were found to	2/8/18	

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F 692	<p>Continued From page 12</p> <p>stage IV chronic kidney disease with hemodialysis, hypertension (HTN), diabetes, and diabetic nephropathy.</p> <p>On 02/29/16 Resident #18's care plan identified, "At risk for complications r/t (in regard to) hemodialysis, ESRD (end stage renal disease). Rsd. (Resident) is on 1500 cc (cubic centimeter)/day fluid restriction. Resident receives HTN medications" as a problem. Interventions to this problem included, "Encourage rsdt. to be compliant with 1500 cc/24 hours fluid restriction" and "Provide diet as ordered."</p> <p>A 12/08/16 physician order documented, "Fluid restriction ...7A-7P and 7P-7A no more than 300 cc from nursing Q (every) 12-hour shift...Only document what nursing provides (For your information: Dietary provides 900 cc (daily) on meal trays)."</p> <p>The resident's 10/20/17 quarterly minimum data set (MDS) documented Resident #18's cognition was intact, he exhibited no behaviors including resistance to care, the resident was independent with eating and required only staff assistance with setting up his meal tray, his weight was stable, and the resident was receiving dialysis.</p> <p>Tray slips for Tuesday, 01/09/18, (a non-dialysis day for Resident #18), documented he received 6 ounces of apple juice and 8 ounces of coffee for breakfast, a bowl chicken soup and 8 ounces of tea for lunch, and bowl of vegetable soup and 8 ounces of tea for supper. (Therefore, on 01/09/18 Resident #18 received 14 ounces of fluid for breakfast + 16 ounces of fluid for lunch + 16 ounces of fluid for supper = 46 ounces or 1380</p>	F 692	<p>have fluid restrictions.</p> <p>Dietary staff were in-serviced on following the fluid restrictions ordered, and not to give any extra fluids that are not listed on resident's tray cards.</p> <p>Nursing staff was in-serviced on not providing a water pitcher to residents with fluid restriction orders and only to provide the water allowed on medication passes per orders.</p> <p>All new orders will be reviewed daily (M-F) by administrative nursing personnel for any new orders related to fluid restrictions.</p> <p>All residents with orders for fluid restrictive diets are discussed by the CDM and DON or designee. Amounts to come from each department are verified and orders are written appropriately.</p> <p>CDM will audit ALL residents on fluid restrictions each week for 4 weeks and monthly thereafter to ensure the appropriate amounts are ordered as well as delivered.</p> <p>Audit results will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 692	<p>Continued From page 13 cc of fluid for the day from dietary).</p> <p>Review of the January 2018 electronic medication administration record (e-MAR) revealed Resident #18 received 500 cc of fluid with medications on 01/09/18. (Therefore, Resident #18 was offered 1380 cc from dietary and 500 cc of fluid with medications on 01/09/18 for a total of 1880 cc which exceeded his 1500 cc fluid restriction).</p> <p>During an observation on 01/10/18 at 12:12 PM Resident #18 received 8 ounces of tea, 8 ounces of water, and a bowl of soup on his lunch meal tray.</p> <p>During an observation 01/10/18 at 5:41 PM Resident #18 received 8 ounces of tea and a bowl of soup on his supper tray.</p> <p>During an interview with the Dietary Manager (DM) on 01/10/18 at 5:50 PM she stated Wednesdays (such as 01/10/18) were a dialysis day for Resident #18. She reported on dialysis days the resident received a snack before leaving the facility in the mornings which consisted of a ham sandwich and a carton of milk. The DM commented the resident really liked soup, and had requested soup with lunch and supper. The DM went to the tray line and using a ladle determined a bowl of soup contained 8 - 9 ounces of fluid. (Therefore, on 01/10/18 Resident #18 received 8 ounces of fluid for breakfast + 24 ounces of fluid for lunch + 16 ounces of fluid for supper = 48 ounces or 1440 cc of fluid for the day from dietary).</p> <p>Review of the January 2018 e-MAR revealed Resident #18 received 464 cc of fluid with medications on 01/10/18. (Therefore, Resident</p>	F 692			

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F 692	<p>Continued From page 14</p> <p>#18 was offered 1440 cc from dietary and 464 cc of fluid with medications on 01/10/18 for a total of 1904 cc which exceeded his 1500 cc fluid restriction).</p> <p>Tray slips for Thursday, 01/11/18, (a non-dialysis day for Resident #18), documented he received 6 ounces of apple juice and 8 ounces of coffee for breakfast, a bowl chicken soup and 8 ounces of tea for lunch, and bowl of vegetable soup and 8 ounces of tea for supper. (Therefore, on 01/11/18 Resident #18 received 14 ounces of fluid for breakfast + 16 ounces of fluid for lunch + 16 ounces of fluid for supper = 46 ounces or 1380 cc of fluid for the day from dietary).</p> <p>Review of the January 2018 e-MAR revealed Resident #18 received 420 cc of fluid with medications on 01/11/18. (Therefore, Resident #18 was offered 1380 cc from dietary and 420 cc of fluid with medications on 01/11/18 for a total of 1800 cc which exceeded his 1500 cc fluid restriction).</p> <p>During an interview with Nurse #4 on 01/11/18 at 10:45 AM she stated she cared for Resident #18 on both 7A - 7P and 7P to 7A shifts. She reported she provided the resident with 30 - 60 cc of fluid per medications pass, and the resident received two passes on 7A - 7P and one pass on 7P- 7A (90 to 180 cc day). She commented she tried to keep fluids with medications to a minimum because she was not sure what fluids dietary was providing the resident. According to Nurse #4, nurses documented the amount of fluid given to residents in the e-MAR system, but she reported she thought the nursing assistants (NAs) only documented the percent of the meals eaten in their electronic record keeping.</p>	F 692			

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F 692	Continued From page 15 During an interview with the DM and Registered Dietitian (RD) on 01/11/18 at 3:38 PM the DM stated Resident #18 had requested soup with his lunch and supper meals. She reported she was more focused on honoring the resident's preferences, and forgot how it might affect his fluid restriction. The RD commented she did not think the resident drank all of the fluids provided on his meal trays, and she had never received any calls from the dialysis center about the resident being in fluid overload. The DM remarked excess fluid was pulled off the resident during the dialysis process. During an interview with NA #3 on 01/12/18 at 11:03 AM she confirmed that NAs only documented the percent of meals consumed in the electronic medical record system. However, for residents on fluid restriction, she reported the NAs were supposed to tell the nurses about how much residents were drinking with meals so they could adjust the amount of fluid they were giving residents with medication passes. During an interview with Nurse #3 on 01/12/18 at 11:10 AM she stated nurses documented cc's of fluid provided to residents on each 12-hour shift in the e-MAR. She reported there was an order not to provide more than 300 cc of fluid per 12-hour shift by nursing for Resident #18. She commented dietary was given an amount of fluid which they were not to exceed when placing beverages on this resident's meal trays. She remarked it was up to dietary not to exceed the amount of fluid they were allocated to provide. During an interview with the Assistant Dietary Manager (ADM) on 01/12/18 at 11:18 AM she	F 692			

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F 692	Continued From page 16 explained when residents were on fluid restriction the ounces of beverage for each meal were listed on the tray slips, and the tray slips were what the dietary staff utilized in determining what to place on the resident trays. She stated soup, ice cream, jell-o, and all foods which melted into liquids had to be counted toward the restricted fluid total for the day. During an interview with the Acting Director of Nursing (DON) on 01/12/18 at 11:55 AM she stated residents on fluid restriction were to have a physician order for specifying the exact cc's of fluid allowed. She explained nursing looked at the number of medication passes the restricted residents received and the amount of fluid needed to take the medications at each pass. She reported these amounts were totaled and then the balance of fluid from the orders was relayed to dietary which divided their allocations between three meals. According to the Acting DON, dietary and nursing were not to exceed the totals they were provided.	F 692			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		2/8/18	

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F 812	<p>Continued From page 17</p> <p>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 observation and staff interview the facility failed to maintain the temperature of a cold salad prepared with mayonnaise at or below 41 degrees Fahrenheit during the entire operation of the trayline. The facility also failed to de-stain or discard coffee mugs which had dark brown stains and/or abrasions inside of them, and the facility failed to label and date opened food items and leftovers in storage areas. Findings included:</p> <p>1. At 12:07 PM on 01/09/18 a calibrated thermometer used to check the temperature of Cole slaw at the trayline registered 53.1 degrees Fahrenheit. At 12:10 PM on 01/09/18 a calibrated thermometer used to check the temperature of another bowl of Cole slaw at the trayline registered 51.3 degrees Fahrenheit. At this time the assistant dietary manager (ADM) stated the dietary staff was in the process of filling the last meal cart with resident trays. She reported she finished assembling the slaw made with chilled ingredients around 9:30 AM on 01/09/18, placed it in bowls, placed the bowls in racks, and transferred the racks to the walk-in refrigerator. She commented the slaw remained in refrigeration until about 11:25 AM on 01/09/18 when it was placed at the trayline which began operation at 11:30 AM. According to the ADM, the Cole slaw contained cabbage, salt, pepper, sugar, mayonnaise, and Cole slaw dressing.</p>	F 812	<p>1. All dietary staff have been inserviced on the appropriate food temperature standards for hot and cold food preparation, storage and serving.</p> <p>2. All dinexware identified as being stained and/or abraded were discarded on 1/10/18.</p> <p>3. Items identified as being improperly stored and labeled on 1/8/18 were discarded upon discovery that they were opened and not labeled and dated properly. Item identified as being improperly stored and labeled upon inspection on 1/10/18 was discarded.</p> <p>All other boxes and items in the dry storage and walk-in refrigerator/freezer were inspected by the Dietary Manager and Assistant to ensure there were no other items improperly labeled and dated.</p> <p>All dietary staff have been inserviced on proper food storage, preparation, temperatures for hot and cold foods and food safety requirements. Additionally, dietary staff have been inserviced on proper destaining process and/or discarding abraded dinexware. Dietary</p>		

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F 812	<p>Continued From page 18</p> <p>Both the dietary manager (DM) and ADM stated cold salads made with mayonnaise should remain at or below 41 degrees Fahrenheit during the entire trayline operation.</p> <p>At 3:38 PM on 01/11/18 the DM stated all but one dietary staff member had received January 2018 training on maintaining chilled foods at the trayline. She reported during this training staff were instructed to try and prepare cold salads the day before serving them and to use chilled ingredients when preparing them. However, the DM commented she did not think this training reviewed any special procedures for maintaining the chilled salads at or below 41 degrees Fahrenheit once the trayline began operation. She also remarked that keeping cold salads made with mayonnaise above 41 degrees Fahrenheit for an extended period of time could increase the chance of residents developing a foodborne illness.</p> <p>At 11:18 AM on 01/12/18 the ADM stated on 01/09/18 the dietary staff should not have brought all of the Cole slaw out of the walk-in refrigerator at one time when the lunch trayline began operation. She reported in the past the facility made cold salads on the same day that they were served and had not used ice to keep the salads cold once the trayline began operation, but it was rethinking that philosophy. The ADM commented keeping salads made with mayonnaise above 41 degrees Fahrenheit for long periods of time could promote bacterial growth which could lead to residents getting sick.</p> <p>2. During an inspection of kitchenware, beginning at 9:34 AM on 01/10/18, 15 of 34 plastic coffee mugs (44%) in storage had dark</p>	F 812	<p>staff have also been inserviced on the proper standards and process for food items that have been opened and need to be labeled and dated for future use.</p> <p>Audit tools have been developed and will be performed by Dietary Manager and/or designee on a daily basis (M-F) for 4 weeks to ensure the deficient practice(s) does/do not recur.</p> <p>Results of these audits will be forwarded to the QAPI Committee for further recommendations as necessary.</p>		

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F 812	<p>Continued From page 19</p> <p>brown stains inside of them and/or were abraded on the inside.</p> <p>At 3:38 PM on 01/11/18 the dietary manager (DM) stated the de-staining of kitchenware was on the weekly cleaning schedule. After reviewing her records, she reported the last time kitchenware was de-stained was 12/25/17. The DM commented a commercial product was used for de-staining. She also remarked any abrasions inside the coffee mugs made it more likely that bacteria could be harbored and grow there.</p> <p>At 11:18 AM on 01/12/18 the assistant dietary manager (ADM) stated if the dietary staff observed kitchenware that was badly stained, chipped, or cracked they were supposed to present it to herself or the DM so a decision could be made as to whether it should be discarded or whether de-staining would be sufficient. She commented de-staining with a commercial product was on the weekly cleaning schedule. However, she remarked she was not sure of the last time the coffee mugs were actually inspected for staining issues. According to the ADM, it was easier for bacteria to remain on the surfaces of kitchenware which was abraded.</p> <p>3. During initial tour of the kitchen on 01/08/18, beginning at 2:00 PM, there were food items in dry storage that were opened but without labels and dates. These food items included a 32-ounce bag of brown sugar, a 32-ounce bag of powdered sugar, a bag of elbow macaroni, a 2.75-ounce packet of strawberry gelatin, a 5-pound box of yellow cake mix, and a 12-ounce box of cream of wheat. A container of pork sausage in the walk-in refrigerator did not have a label or date on it. A bag of red potato chunks,</p>	F 812			

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F 812	Continued From page 20 two bags of corn dog nuggets, and a bag of okra pods, which had been opened and stored in the walk-in freezer, were without labels and dates. During a follow-up inspection of storage areas on 01/10/18 at 9:56 AM an opened bag of chicken filets in the walk-in freezer was without a label and a date. At 3:38 PM on 01/11/18 the dietary manager (DM) stated she usually checked for labeling and dating on the two stock days during the week. She reported all opened food items, repackaged food items, and leftovers were supposed to have labels and dates on them. She commented putting labels and dates on food items was important to ensure the older food items were used up first. At 11:18 AM on 01/12/18 the assistant dietary manager (ADM) stated any dietary employee, who opened food items but did not use them all up, was responsible for placing a label and date on the packaging. The ADM reported she checked the storage areas for labeling and dating on Sundays or Mondays and Wednesdays. She commented labeling and dating food items was an important element in the FIFO (first in and first out) principle.	F 812			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		2/8/18	

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F 842	<p>Continued From page 21</p> <p>accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> 	F 842			

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F 842	<p>Continued From page 22</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to document complete and accurate information in the medical record for 1 of 22 Residents (Resident #72) whose records were reviewed. Findings included:</p> <p>Review of the 5-day Minimum Data Set (MDS) dated 12/18/17 revealed Resident #72 was readmitted to the facility from the hospital on 12/11/17 with diagnoses of cerebrovascular accident (CVA), altered mental status (AMS), and seizure disorder.</p> <p>Review of the Physician Orders dated 12/07/17 revealed an order to send Resident #72 to the ER (Emergency Room) for evaluation d/t (due to) AMS (altered mental status.) The order was input</p>	F 842	<p>Resident #72's record was reviewed and found Dr's order was obtained to send resident to the hospital where appropriate care was rendered per diagnosis.</p> <p>Since all residents in facility are at risk for less than comprehensive documentation, on occasion, all nurses were educated on the importance of accurate and complete documentation in the resident medical record.</p> <p>Continuing education with nurses to ensure appropriate utilization of resident EMR (electronic medical record) has been scheduled to include complete and accurate documentation in accordance</p>		

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F 842	<p>Continued From page 23 into the computer by Nurse #3.</p> <p>Review of the Nursing Progress Notes for 12/07/17 revealed no notes documenting any change of condition for Resident #72 or that he was sent to the hospital.</p> <p>In an interview on 01/11/18 at 4:00 PM the Acting Director of Nursing (DON) indicated she was unable to provide any medical record documentation except the order of transfer to the ER (Emergency Room) for Resident #72's change of condition.</p> <p>In a telephone interview on 01/11/18 at 4:15 PM Nurse #3 stated she was the nurse responsible for Resident #72 the day he was sent to the hospital. She indicated Resident #72 was less responsive verbally and was pale. She indicated the former DON (unavailable for interview) the former Unit Manager (unavailable for interview) and former Staff Development Coordinator (SDC) were all in Resident #72's room. Nurse #3 stated the former SDC had called the physician and obtained the order to send Resident #72 to the ER.</p> <p>In a telephone interview on 01/11/18 at 5:20 PM the former SDC stated he was not involved in any way in sending Resident #72 to the hospital. He indicated he was not in the room and did not notify the physician, receive an order for transfer to the ER, or write a progress note about the incident. He stated he was seated at the (nursing) desk and the former DON mentioned Resident #72 was going out to the hospital and that was the extent of his involvement. He indicated that as Resident #72's nurse it was Nurse #3's responsibility to write a progress note</p>	F 842	<p>with accepted professional standards and practice.</p> <p>Daily review (M-F) of medical records for all residents noted to have a change in condition will be performed by DON or designee. If documentation is found to be incomplete, responsible nurse will be notified to return to facility to complete the medical record.</p> <p>Audit results will be forwarded to the QAPI Committee for system oversight and recommendations as necessary.</p>		

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F 842	Continued From page 24 documenting her findings and why the Resident was sent to the hospital.	F 842			
F 880 SS=D	<p>In an interview with the Administrator and the Acting DON on 01/12/18 at 2:35 PM they indicated that at a minimum they expected a progress note to be written in the medical record when a resident was transferred to the hospital.</p> <p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify</p>	F 880		2/8/18	

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F 880	<p>Continued From page 25</p> <p>possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the</p>	F 880	CNA was immediately counselled		

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F 880	Continued From page 26 facility failed to handle dirty linen in a sanitary manner by placing it on the floor for 1 of 1 sampled residents (Resident #23). Findings included: In an observation on 01/11/18 at 10:42 AM Resident #23's visibly soiled draw sheet was removed from the bed by Nursing Assistant (NA) #1. NA #1 rolled the soiled sheet up and dropped it on the floor next to the bed. After a clean sheet was placed on Resident #23's bed, NA #1 picked the soiled sheet up from the floor and carried it into the bathroom where it was placed in a plastic bag. In an interview on 01/11/18 at 10:58 AM NA #1 stated she did not realize she had thrown the soiled linen on the floor and that she was just not thinking. In an interview with the Administrator and Acting Director of Nursing on 01/12/18 at 2:35 PM it was stated that it was their expectation that soiled linen should be bagged and not placed directly on the floor.	F 880	regarding appropriate handling of linen per infection control standards. Nurses and CNA's were inserviced on proper handling of clean and soiled linens and also assigned "Infection Control: The Basics" in facility computer based learning (Relias Learning). Rolls of both large and small plastic bags are now stocked on linen carts for easy accessibility and use as indicated. SDC will perform a minimum of 10 random observations of linen handling on a weekly basis for 4 weeks and record audit findings. Immediate coaching or correction will be provided as necessary. Observation results will be forwarded to the QAPI Committee for further recommendations as necessary.		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 919		2/7/18	

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F 919	<p>Continued From page 27</p> <p>Based on observations and staff interviews, the call bell failed to activate when pressed in 1 of 1 resident room (beds 502A and 502B) in the facility.</p> <p>The findings included:</p> <p>On 01/08/18 beginning at 2:30 PM, call bells were tested in 1 resident room. In 1 of the 1 rooms (beds 502A and 502B) when the call bell was activated, the call light did not illuminate outside the resident door, and the call bell failed to sound at the nursing station. The maintenance Director (MD) stated the problem was the bulb above the resident's door to the call bell system needed to be replaced. The MD reported he checked their call bells monthly, but was not aware of a problem with the call bell system in room 502A and 502B. He commented he did not know the exact date when the call bell was last checked in room 502.</p> <p>On 01/08/18 at 2:35 PM., Nurse #2 stated she was not aware that a call light was not working inside room and above the door for room 502. She stated both residents were capable of using their call light, but they had not voiced any complaints about it not working. She stated if the residents needed anything, they would could just call out for an aide or nurse. She stated she never checked if their call lights were working or not working, or questioned why they were calling out instead of using their call light.</p> <p>In an interview on 01/11/18 at 9:40 AM with both residents in room 502, they stated they used their call bells, and were not aware their call lights were not working on 01/08/18.</p>	F 919	<p>The bulb was replaced by Maintenance to the nurse call fixture over the door on 1/9/18. It was tested and worked properly.</p> <p>All call bells were tested on 1/11/18 for proper operation and verified by Maintenance Director, Administrator and Environmental Director as working properly. Upon activation in the resident room, all lights illuminated over the doors and room number and sound notification was noted to the nurse annunciator at the nurses' station.</p> <p>Staff have been inserviced on the appropriate steps to take by notifying Maintenance through the TELs (work order) system and providing an alternate method of notifying staff for resident assistance needs when it is noted that a call light is not working properly or to investigate why a resident may be calling out for assistance, instead of utilizing their call lights.</p> <p>An audit has been initiated immediately on a weekly basis for 4 weeks to test random call lights throughout the facility.</p> <p>The TELs system has also been updated to populate a random Nurse Call Testing on a weekly basis, as well as, the monthly full testing per regulatory recommendations. A log has been added to the system for record keeping purposes.</p> <p>Audit results will be forwarded to the QAPI</p>		

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

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F 919	Continued From page 28 An observation on 01/11/18 at 10:00 AM revealed the non-functioning call lights in room 502 were fixed and functioning properly. During an interview with the facility Administrator on 01/12/18 at 10:30 AM., the Administrator indicated that it was her expectation that all call lights would be working, and her expectation was not being met with regard to the residents in room 502. She stated if a call light was not working, the staff would report the problem to in-house maintenance or after hours by filling out maintenance work requisition form, and (if needed) provide the resident with a manual hand bell to be used until their call light was fixed.	F 919	Committee for further recommendations as necessary. Maintenance Director is responsible for ensuring proper testing and documentation.		