STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	C 02/28/2018

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 000	INITIAL COMMENTS A follow up to complaint (Event 8II112) and complaint (Event ZBDZ11) was conducted 02/26/18 through 02/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. CFR 483.35 at F726 at a scope and severity of J. Tag F684 constituted substandard quality of care. Immediate jeopardy began on 02/12/18 and was removed on 02/28/18. A extended survey was completed.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		3/27/18

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

Electronically Signed | 03/23/2018

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and medical doctor interviews the facility failed to notify the medial doctor of a fall that resulted in major injury for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 fell from the bed during incontinent care and Nurse #2 did not notify the medial doctor that Resident #1 had fallen or was complaining of pain and was	F 580	#1 Corrective Action for the resident found to be affected Resident was assessed by the nurse , doctor called and resident sent to the ER #2 Corrective action taken for these residents having the potential to be	

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F 580	Continued From page 2 requesting to go to the hospital. Immediate jeopardy began on 02/12/18 when Nursing Assistant (NA) #1 entered Resident #1's room to provide incontinent care. NA #1 asked Resident #1 to roll onto her left side and grabbed the pad to assist. Resident #1 flung her right leg over her left leg and it propelled her off the bed and onto the floor. Resident #1 was complaining of pain to her left side and requested to go the hospital. Nurse #2 did not notify the medical doctor at the time of the fall. The Medical Doctor was not notified until 02/13/18 at 1:00 AM when Nurse #1 assessed Resident #1's complaints of pain and was notified by Resident #1 that she had fallen out of bed on the previous shift. Nurse #1 notified the on call medical doctor of Resident #1's complaints and an order was received to send her to the Emergency Room for evaluation. Immediate jeopardy was removed on 02/28/18 at 6:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to completed education and ensure monitoring systems put into place for medical doctor notification are effective. The findings included: Resident #1 was initially admitted to the facility on 08/31/11 and most recently readmitted to the facility on 02/20/18 with diagnoses that included subcutaneous hematoma, history of pulmonary embolism, coronary artery disease, dementia, diabetes mellitus and others.	F 580	affected On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident□s medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review. #3 Measures and systemic changes put into place to ensure practice does not reoccur On 2/27/18 The Director of Nursing and Nurse Managers re-educated all current Licensed Nurses and Agency Nurses currently working in the facility, regarding the facility policy for Changes in Resident Condition, with a focus on Notification of the Physician following an Incident/Accident. A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit Manager on Duty or the Nurse Manager on Call when a resident has a fall. The Unit Manager on Duty or the Nurse Manager on Call will be listed on the Daily Assignment Sheet along with contact information. This will be posted at	

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F 580	Continued From page 3 Review of the most recent quarterly Minimum Data Set (MDS) dated 12/30/17 revealed that Resident #1 was mildly cognitively impaired and required extensive assistance of 1 staff member with bed mobility and toileting. The MDS further revealed that Resident #1 had received 7 days of anticoagulant therapy. Review of a facility document titled Incident/Accident Report dated 02/12/18 at 9:00 PM read in part, Nursing Assistant (NA) #1 was preparing to provide incontinent care to Resident #1. Resident #1 was asked by NA #1 to roll onto her left side, Resident #1 flung her right leg over the left leg propelling her body off the left side of the bed onto the floor. The report indicated that the on call Medical Doctor (MD) was notified on 02/13/18 at 1:00 AM by Nurse #1. The report was signed by the Director of Nursing (DON). An interview was conducted with NA #1 on 02/26/18 at 2:24 PM. NA #1 confirmed that she was caring for Resident #1 on 02/12/18 for the first time. She stated she had entered Resident #1's room at 9:00 PM to provide incontinent care to Resident #1. NA #1 stated that she had instructed Resident #1 to turn onto her left side and grabbed a hold of the pad, Resident #1 took her right leg and flung it over her left leg and it propelled her body off the left side of the bed onto the floor. NA #1 stated she immediately asked Resident #1 if she was ok and she replied that she was not ok and to get her out of the floor. She added that Resident #1 was lying on her back partially under the bed and was complaining of pain and stated "my ribs are broken." She added that Mediation Aide (MA) #1 was in the room at the same time administering medications to Resident #1's roommate. MA #1 heard the fall	F 580	each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the Physician was notified as well as making any recommendations for ongoing interventions and treatments. On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding this new process for notification of the Physician for residents having a fall. On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a fall or a significant change in condition. This education included that Nurse Aides will immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation. No staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 2/27/18. New Agency staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident assignment. On 2/28/18 a new process was initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident/Accident reports to validate the following process was completed as	

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F 580	Continued From page 4 and went to summons Nurse #2. An interview was conducted with MA #1 on 02/26/18 at 2:44 PM. MA #1 confirmed that she was working on the unit where Resident #1 resided on 02/12/18. MA #1 stated that she had entered Resident #1's room at approximately 9:00 PM to medicate her roommate while NA #1 provided care to Resident #1. MA #1 stated that she heard NA #1 ask Resident #1 to turn onto her left side and then heard Resident #1 fall to the floor. MA #1 stated that she went out to the hallway and motioned for Nurse #2 to come to the room. She stated Nurse #2 entered Resident #1's room and observed her on the floor. She stated that Resident #1 was transferred with the mechanical lift from the floor back to bed. MA #1 stated that she was not able to contact the MD about the fall that was the responsibility of Nurse #2. MA #1 again confirmed that she had not contacted the MD about Resident #1's fall on 02/12/18. An interview was conducted with the Unit Coordinator (UC) on 02/26/18 at 3:28 PM. The UC stated that Nurse #1 had contacted her on 02/13/18 at 1:00 AM and told her that Resident #1 had fallen from bed and was complaining of rib pain and they had sent her to the Emergency Room (ER). The UC stated that Nurse #2 did not know that she was responsible for notifying the MD of Resident #1's fall. The UC added that Nurse #2 should have immediately notified the on call MD after Resident #1 fell from the bed on 02/12/18. An interview was conducted with Nurse #2 on 02/26/18 at 3:37 PM. Nurse #2 confirmed that she was working on 02/12/18 and was working on	F 580	implemented: -the Physician was notified of the event -the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed. 4. Yvonne Washburn, LNHA is responsible for implementing this acceptable plan of correction	

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the unit where Resident #1 resided. She stated that at approximately 9:00 PM she was alerted that Resident #1 was on the floor. Nurse #2 stated that she entered Resident #1's room and NA #1, NA #2, and MA #1 were all in the room. She stated that Resident #1 was requesting to get off the floor. Nurse #2 stated that Resident #1 stated something but she could not recall what it was but it was nothing that was concerning to her. Nurse #2 stated that she waited until the 3 staff members transferred Resident #1 off the floor to the bed and exited the room. Nurse #2 stated that she assumed MA #1 would contact the MD and obtain any new orders. Nurse #2 confirmed that she had not notified the MD of the fall because she "assumed that MA #1 would handle it."

An interview was conducted with the MD on 02/26/18 at 5:17 PM. The MD stated that she directly was not notified of Resident #1's fall on 02/12/18 until Resident #1 was in the hospital. She stated that the on call MD was notified on 02/13/18 at approximately 1:00 AM. The MD stated that she would have expected that the on call MD would have been notified in a reasonable time frame within 1 hour but certainly sooner than 4 hours of the fall and Resident #1's complaints of pain. The MD explained that when a resident who was receiving anticoagulation falls we always request closer monitoring of the resident and that would have been true of Resident #1's fall on 02/12/18.

An interview was conducted with the DON on 02/26/18 at 6:06 PM. The DON stated that Nurse #2 should have notified the MD immediately after she assessed Resident #1's injuries and her complaints of pain. The DON stated that as a part of their investigation they learned that Nurse #2

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was not familiar with MAs and what they could and could not do and she assumed that MA #1 would contact the MD and handle any new orders obtained.

An interview was conducted with Nurse #1 on 02/27/18 at 8:47 AM. Nurse #1 confirmed that she worked 3rd shift on 02/12/18. She stated that on 02/13/18 at approximately 12:30 AM Resident #1 complained of pain. Nurse #1 stated that it was unusual for Resident #1 to complain of pain so she went to her room to find out what was going on. When questioned by Nurse #1 about her pain Resident #1 stated "they broke my ribs when they pushed me out of bed." Nurse #1 stated that upon assessment Resident #1's left lower rib area and left upper abdominal area were distended and hurting her. She added that Resident #1 was not able to rate her pain but requested to go to the hospital. Nurse #1 stated she called the on call MD and notified him of Resident #1's complaints and received an order to send Resident #1 to the ER for evaluation.

Review of the local hospital ER report dated 02/13/18 read in part, that Resident #1 reported a fall at the facility and complained of left flank pain and swelling. Upon evaluation the MD indicated that Resident #1 had soft tissue swelling and ecchymosis (discoloration of the skin that resulted from bleeding underneath) right mid lower leg and soft tissue swelling with tenderness, induration, and ecchymosis to the left lower abdomen consistent with probable subcutaneous hematoma.

Review of a Computed Tomography (CT) of the abdomen that was completed in the ER on 02/13/18 confirmed that Resident #1 had a

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subcutaneous hematoma with active extravasation (leaking of fluid).

The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM.

Credible Allegation F580:
1. On February 12, 2018 at approximately 9:00 PM Nurse Aide (NA) #1 entered Resident #1's room to provide incontinent care and Certified Medication Aide (CMA) #1 entered the same room to administer medications to the roommate. Resident #1 requires assistance with bed mobility and while NA #1 was attempting to turn her in the bed her leg "flopped" off the side of the bed causing her to fall to the floor. At 9:05pm CMA #1 left the room to get Nurse #2 and then went to get NA #2 (who gathered the mechanical lift and came to the room). Agency Nurse #2 stated she went to the door and waited until Resident #1 was placed back in bed by NA #2. Agency Nurse #2 explained that she completed no further assessment on Resident #1 after she fell from bed. On February 12, 2018 at 11:00 pm report was given from Agency Nurse #2 to the on-coming Nurse#1, but did not include information regarding this fall. On February 13, 2018 at 1:00am Nurse #1 entered Resident #1's room, at which time Resident #1 was complaining of pain in her left flank area, and reported a fall from the bed several hours earlier. On February 13, 2018 at 1:15am Nurse #1 notified the on call Physician regarding the fall and subsequent assessment of Resident #1, orders were received to send her to the Emergency Room for further evaluation.

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A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) on 2/27/18 and it was determined that Agency Nurse #2 was confused regarding the delineation of responsibilities when a Nurse is working with a Certified Medication Aide which resulted in her lack of timely response to the incident that occurred on 02/12/18. Agency Nurse #2 stated that she was not accustomed to working with CMAs and thought CMA #1 was completing the assessment and notifying the physician. The root cause analysis identified that Agency Nurse #2 did not receive orientation or training from the facility regarding a nurse's responsibilities at the facility, including the need to assess a resident and to notify a resident's physician after a resident experienced a fall or a significant change in a condition, prior to beginning her work assignment on 2/12/18 which was her first day working at the facility.

2. All residents who have had a fall have a potential to be affected by this alleged deficient practice. On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident's medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review.

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3. On 2/27/18 The Director of Nursing and Nurse Managers re-educated all current Licensed Nurses and Agency Nurses currently working in the facility, regarding the facility policy for "Changes in Resident Condition", with a focus on Notification of the Physician following an Incident/Accident.

A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit Manager on Duty or the Nurse Manager on Call when a resident has a fall. The Unit Manager on Duty or the Nurse Manager on Call will be listed on the Daily Assignment Sheet along with contact information. This will be posted at each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the Physician was notified as well as making any recommendations for ongoing interventions and treatments.

On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding this new process for notification of the Physician for residents having a fall.

On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a fall or a significant change in condition. This education will include that Nurse Aides will immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation.
No staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to

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F 580	Continued From page 10 beginning work after 2/27/18. New Agency staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident assignment. On 2/28/18 a new process will be initiated during the morning clinical meeting. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hour report and/or with Incident/Accident reports to validate the following process was completed as implemented: -the Physician was notified of the event -the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed. 4. The Administrator is responsible for implementing this acceptable plan of correction Immediate jeopardy was removed on 02/28/18 at 6:20 PM when nursing staff interviews revealed that they had received education on the facility's revised procedure for notifying the MD after a fall or significant change in condition.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/27/18

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F 684	Continued From page 11 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff and Medical Doctor interviews the facility failed to assess a resident following a fall from bed that resulted in injury and failed to report the fall to the oncoming shift for 1 of 3 residents sampled for supervision to prevent accidents (Resident #1). Immediate jeopardy began on 02/12/18 when Resident #1 fell from the bed to the floor and Nurse #2 completed no assessment of Resident #1. Several hours later Resident #1 was sent to the Emergency Room for evaluation where it was discovered that Resident #1 sustained a subcutaneous hematoma to the abdomen that required evacuation and required placement of wound vacuum. Immediate jeopardy was removed on 02/28/18 at 6:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place for resident assessment following a fall or a significant change in condition are effective. The findings included: Resident #1 was initially admitted to the facility on	F 684	#1 Corrective Action for the resident found to be affected Resident was assessed by the nurse , doctor called and resident sent to the ER #2 Corrective action taken for these residents having the potential to be affected On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident□s medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review. #3 Measures and systemic changes put into place to ensure practice does not	

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F 684	Continued From page 12 08/31/11 and most recently readmitted to the facility on 02/20/18 with diagnoses that included subcutaneous hematoma, history of pulmonary embolism, coronary artery disease, dementia, diabetes mellitus and others. Review of a physician order dated 08/28/16 read, Eliquis (anticoagulant used to prevent deep vein thrombosis) 5 milligrams (mg), give ½ tablet (2.5 mg) by mouth 2 times a day. Review of the most recent quarterly Minimum Data Set (MDS) dated 12/30/17 revealed that Resident #1 was mildly cognitively impaired and required extensive assistance of 1 staff member with bed mobility and toileting. The MDS further revealed that Resident #1 had received 7 days of anticoagulation medication. Review of a facility document titled Incident/Accident Report dated 02/12/18 at 9:00 PM read in part, Nursing Assistant (NA) #1 was preparing to provide incontinent care to Resident #1. Resident #1 was asked by NA #1 to roll onto her left side, Resident #1 flung her right leg over the left leg propelling her body off the left side of the bed onto the floor. The report was signed by the Director of Nursing (DON). An interview was conducted with NA #1 on 02/26/18 at 2:24 PM. NA #1 confirmed that she was caring for Resident #1 on 02/12/18 for the first time. She stated she had entered Resident #1's room at 9:00 PM to provide incontinent care to Resident #1. NA #1 stated that she had instructed Resident #1 to turn onto her left side and grabbed a hold of the pad, Resident #1 took her right leg and flung it over her left leg and it propelled her body off the left side of the bed onto	F 684	reoccur On 2/27/18 The Director of Nursing and Nurse Managers re-educated current Licensed Nurses and current Agency Nurses regarding the facility policy for “Changes in Resident Condition”, with a focus on assessment following a fall. Licensed Nurses were re-educated regarding the components of a nursing assessment following a fall to include: -vital signs -neuro checks when a head injury is suspected, changes in level of consciousness occurs or subtle changes in cognition -check the skin for bruising, abrasions, changes in sensation and deformity -range of motion of extremities -evaluate pain for severity and location A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit Manager on Duty or the Nurse Manager on Call when a resident has a fall. The Unit Manager on Duty or the Nurse Manager on Call will be listed on the Daily Assignment Sheet along with contact information. This will be posted at each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the Physician was notified as well as making any recommendations for ongoing interventions and treatments. On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding	

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F 684	Continued From page 13 the floor. NA #1 stated she immediately asked Resident #1 if she was ok and she replied that she was not ok and to get her out of the floor. She added that Resident #1 was lying on her back partially under the bed and was complaining of pain and stated "my ribs are broken." She added that Mediation Aide (MA) #1 was in the room at the same time administering medications to Resident #1's roommate. MA #1 heard the fall and went to summon Nurse #2. NA #1 stated that she did not observe Nurse #2 do any assessment of Resident #1, she observed her on the floor and after we transferred her back to bed Nurse #2 exited the room. An interview was conducted with MA #1 on 02/26/18 at 2:44 PM. MA #1 confirmed that she was working on the unit where Resident #1 resided on 02/12/18. MA #1 stated that she had entered Resident #1's room at approximately 9:00 PM to medicate her roommate while NA #1 provided care to Resident #1. MA #1 stated that she heard NA #1 ask Resident #1 to turn onto her left side and then heard Resident #1 fall to the floor. MA #1 stated that she went out to the hallway and motioned for Nurse #2 to come to the room. She stated Nurse #2 entered Resident #1's room and observed her on the floor but completed no assessment of Resident #1. She stated that Resident #1 was transferred with the mechanical lift from the floor back to bed and at that point Nurse #2 exited the room. MA #1 stated that she was not able to assess Resident #1 that was the responsibility of the nurse. MA #1 stated that she had counted the medication cart with Nurse #1 at that end of her shift, but Nurse #2 was responsible for giving report to Nurse #1 about the residents and their condition.	F 684	this new process for notification of the Physician for residents having a fall. On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a fall or a significant change in condition. This education included that Nurse Aides will immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation. No staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 2/27/18. New Agency staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident assignment. On 2/28/18 a new process was initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident/Accident reports to validate the following process was completed as implemented: -the Physician was notified of the event -the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee	

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F 684	Continued From page 14 An interview was conducted with NA #2 on 02/26/18 at 3:02 PM. NA #2 confirmed that she routinely cared for Resident #1 on day shift. She added that on the evening of 02/12/18 she was working over on the unit but was not responsible for Resident #1 that evening. NA #2 stated that at approximately 9:00 PM MA #1 stated "I need your help to get Resident #1 up off the floor." NA #2 stated that she went and got the lift and entered Resident #1's room. She stated that when she entered Resident #1's room her bed was elevated and Resident #1 was lying on her back under the bed. NA #2 stated that Resident #1 stated "get me off the floor I broke my ribs and get me to the hospital." She added that Nurse #2 was in the room but did not observe her do any type of assessment of Resident #1. NA #2 stated that they used the lift and assisted Resident #1 back to bed and NA #1 finished providing incontinent care to her. She added that Resident #1 was very adamant that she wanted to go to the hospital even when Nurse #2 was in the room. NA #2 stated that MA #1 stated to Resident #1 that she could not make the call to send her to the Emergency Room (ER) but would again let Nurse #2 know that she wanted to go. An interview was conducted with Nurse #2 on 02/26/18 at 3:37 PM. Nurse #2 confirmed that she was working on 02/12/18 and was working on the unit where Resident #1 resided. She stated that at approximately 9:00 PM she was alerted that Resident #1 was on the floor. Nurse #2 stated that she entered Resident #1's room and NA #1, NA #2, and MA #1 were all in the room. She stated that Resident #1 was requesting to get off the floor. Nurse #2 stated that Resident #1 stated something but she could not recall what it was but it was nothing that was concerning to her.	F 684	will make recommendations as needed. 4. Yvonne Washburn, LNHA is responsible for implementing this acceptable plan of correction. Data from monitor will be brought to the weekly Ad Hoc QAPI meeting for 12 weeks and than Monthly for 3 months.	

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Nurse #2 stated that she waited until the 3 staff members transferred Resident #1 off the floor to the bed and exited the room. Nurse #2 stated she completed no assessment of Resident #1 and during report to Nurse #1 did not report that Resident #1 had fallen earlier in the shift. Nurse #2 stated she assumed MA #1 would assess Resident #1 for any injuries and would report the fall to Nurse #1 at the end of her shift.

An interview was conducted with the DON on 02/26/18 at 6:06 PM. The DON stated that she had received a call at around 1:00 AM on 02/13/18 from the staff alerting her that Resident #1 had fallen and had a hematoma and had gone to the ER. The DON stated that she obtained statements from the NAs and the MA and discovered that NA #1 was providing incontinent care and asked Resident #1 to turn onto her side and she flung one leg over the other and it caused her to roll out of the bed. She added that MA #1 was in the room medicating Resident #1's roommate and heard the fall and immediately went and got Nurse #2. They eventually got Resident #1 off the floor and back in bed and then later they sent her to the ER. The DON stated that she would have expected Nurse #2 to complete a head to toe assessment of Resident #1 and notify the on call MD for any additional orders. She also stated that if Resident #1 was requesting to go to the hospital than Nurse #2 should have also notified the on call Medical Doctor (MD) of her request in addition, Nurse #2 should have reported the fall to Nurse #1 at the end of her shift.

Review of facility document titled Situation, Background, Assessment, and Recommendation (SBAR) that was dated 02/13/18 at 1:56 AM and

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completed by Nurse #1 was reviewed. The SBAR indicated that Resident #1 complained of pain and when questioned where she was hurt she stated she had broken ribs and her right leg hurt. Nurse #1 inquired how she got hurt and Resident #1 stated that "she got thrown onto the floor by the day staff and thrown back into bed." Resident #1's vital signs were: blood pressure: 194/78, pulse: 100, respirations: 20, and temperature: 96.9. The SBAR indicated that Resident #1 had decreased mobility and had pain when moved side to side or moved her right leg. The SBAR further indicated that Resident #1 was experiencing abdominal pain and distention. Nurse #1 indicated that Resident #1 had a distended left lower rib area and left upper abdominal area and also purple bruise to left lower leg. Resident #1 was complaining of pain to both areas. The on call MD was contacted and a new order was obtained to send to the ER for evaluation.

An interview was conducted with Nurse #1 on 02/27/18 at 8:47 AM. Nurse #1 confirmed that she worked 3rd shift on 02/12/18. She stated that on 02/13/18 at approximately 12:30 AM Resident #1 complained of pain. Nurse #1 stated that it was unusual for Resident #1 to complain of pain so she went to her room to find out what was going on. When questioned by Nurse #1 about her pain Resident #1 stated "they broke my ribs when they pushed me out of bed." Nurse #1 stated that upon assessment Resident #1's left lower rib area and left upper abdominal area were distended and hurting her. She added that Resident #1 was not able to rate her pain but requested to go to the hospital. Nurse #1 stated she called the on call MD and notified him of Resident #1's complaints and received an order

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to send Resident #1 to the ER for evaluation. Nurse #1 confirmed that she had received report from Nurse #2 at the beginning of her shift but the report contained nothing about Resident #1's fall.

A follow up interview was conducted with MA #1 on 02/27/18 at 9:28 AM. MA #2 stated that it did not cross her mind to go and get another nurse to come and assess Resident #1 because she trusted that Nurse #2 was going to take care of it.

An interview was conducted with Resident #1 on 02/28/18 at 9:31 AM. Resident #1 recalled falling from the bed but could not recall the day or time and did not remember which staff were involved. Resident #1 stated I have this wound vacuum attached to my side that drains the fluid out of me. Resident #1 stated "I told them I was hurt and needed to go to the hospital and finally after begging for a while they sent me out of here to the hospital."

Review of the local hospital ER report dated 02/13/18 read in part, that Resident #1 reported a fall at the facility and complained of left flank pain and swelling. Upon evaluation the MD indicated that Resident #1 had soft tissue swelling and ecchymosis (discoloration of the skin that resulted from bleeding underneath) right mid lower leg and soft tissue swelling with tenderness, induration, and ecchymosis to the left lower abdomen consistent with probable subcutaneous hematoma.

Review of a Computed Tomography (CT) of the abdomen that was completed in the ER on 02/13/18 confirmed that Resident #1 had a subcutaneous hematoma with active extravasation (leaking of fluid).

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An interview was conducted with the MD on 02/26/18 at 5:17 PM. The MD explained that when a resident who was receiving anticoagulation experienced a fall, we always request closer monitoring of the resident and that would have been true of Resident #1's fall on 02/12/18. She added that the closer monitoring would have included an initial through assessment of Resident #1 and then to observe for any changes that varied from the initial assessment. The staff could not have stopped the formation of the hematoma following the fall, however closer monitoring of the resident was certainly warranted. The treatment of Resident #1 would have been to observe her physically and hemodynamically (flow of blood within the organs and tissues in the body) and if any changes occurred then surgical intervention would have been needed.

The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM.

Credible Allegation F684:

1. On February 12, 2018 at approximately 9:00pm Nurse Aide (NA) #1 entered Resident #1's room to provide incontinent care and Certified Medication Aide (CMA) #1 entered the same room to administer medications to the roommate. Resident #1 requires assistance with bed mobility and while NA #1 was attempting to turn her in the bed her leg "flopped" off the side of the bed causing her to fall to the floor. At 9:05pm CMA #1 left the room to get Nurse #2 and then

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went to get NA #2 (who gathered the mechanical lift and came to the room). Agency Nurse #2 stated she went to the door and waited until Resident #1 was placed back in bed by NA #2. Agency Nurse #2 explained that she completed no further assessment on Resident #1 after she fell from bed. On February 12, 2018 at 11:00 pm report was given from Agency Nurse #2 to the on-coming Nurse#1, but did not include information regarding this fall. On February 13, 2018 at 1:00am Nurse #1 entered Resident #1's room, at which time Resident #1 was complaining of pain in her left flank area, and reported a fall from the bed several hours earlier. On February 13, 2018 at 1:15am Nurse #1 notified the on call Physician regarding the fall and subsequent assessment of Resident #1, orders were received to send her to the Emergency Room for further evaluation.

A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) on 2/27/18 and it was determined that Agency Nurse #2 was confused regarding the delineation of responsibilities when a Nurse is working with a Certified Medication Aide which resulted in her lack of timely response to the incident that occurred on 02/12/18. Agency Nurse #2 stated that she was not accustomed to working with CMAs and thought CMA #1 was completing the assessment and notifying the physician. The root cause analysis identified that Agency Nurse #2 did not receive orientation or training from the facility regarding a nurse's responsibilities at the facility, including the need to assess a resident and to notify a resident's physician after a resident experienced a fall or a significant change in a condition, prior to beginning her work assignment on 2/12/18 which was her first day working at the facility.

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2. All residents who have had a fall or significant change in condition have a potential to be affected by this alleged deficient practice. On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident's medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review.

3. On 2/27/18 The Director of Nursing and Nurse Managers re-educated current Licensed Nurses and current Agency Nurses regarding the facility policy for "Changes in Resident Condition", with a focus on assessment following a fall.

Licensed Nurses were re-educated regarding the components of a nursing assessment following a fall to include:
-vital signs
-neuro checks when a head injury is suspected, changes in level of consciousness occurs or subtle changes in cognition
-check the skin for bruising, abrasions, changes in sensation and deformity
-range of motion of extremities
-evaluate pain for severity and location

A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit

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Manager on Duty or the Nurse Manager on Call when a resident has a fall. The Unit Manager on Duty or the Nurse Manager on Call will be listed on the Daily Assignment Sheet along with contact information. This will be posted at each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the nursing assessment was completed according to guidelines listed above as well as making any recommendations for ongoing interventions and treatments.

On 2/27/18 The Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding this new process for assessment of residents following a fall.

On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a fall or a significant change in condition. This education will include that Nurse Aides will immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation.

No staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 2/27/18. New Agency staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident assignment.

On 2/28/18 a new process will be initiated during the morning clinical meeting. This will include a

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F 684	Continued From page 22 review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hour report and/or with Incident/Accident reports to validate the following process was completed as implemented. -an Situation Background Assessment Recommendation (SBAR) or Nursing progress note is present to document completion of a nursing assessment as outlined in the guideline. -the Director of Nursing and Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed. 4. The Administrator is responsible for implementing this acceptable plan of correction. Immediate jeopardy was removed on 02/28/18 at 6:20 PM when nursing staff interviews revealed that they had received education on the facility's revised procedure for assessing a resident after a fall or significant change in condition that included a head to toe assessment, vital signs, neurological checks, and pain assessment.	F 684		
F 689 SS=G	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	F 689		3/27/18

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F 689	Continued From page 23 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility failed to prevent a resident from falling from bed and sustaining injury for 1 of 3 residents sampled for accidents (Resident #1). Resident #1 fell from the bed during incontinent care and sustained a subcutaneous hematoma that required evacuation (removal) and required placement of a wound vacuum. The findings included: Resident #1 was initially admitted to the facility on 08/31/11 and most recently readmitted to the facility on 02/20/18 with diagnoses that included subcutaneous hematoma, history of pulmonary embolism, coronary artery disease, dementia, and diabetes mellitus. Review of a care plan initiated on 09/20/17 read in part, Resident #1 was at risk for falls related to confusion, incontinence, and decreased mobility. The goal of stated care plan was Resident #1 would be free of falls through the review date. The interventions included: anticipate and meet Resident #1's needs, be sure call light was within reach and encourage Resident #1 to use it for assistance, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, and follow facility fall protocol if a fall should occur. Review of a fall risk assessment dated 12/28/17 revealed that Resident #1 was at high risk for falls.	F 689	F689 #1 Corrective Action for Resident # 1 Resident is receiving incontinent care to prevent injury. #2 Corrected action taken for those residents having the potential to be affected All residents requiring incontinent care while in bed are at risk for this alleged deficient practice. On 3/22/18 an audit was conducted by the DON and Nurse Managers to identify current residents requiring assistance with incontinent care while in bed. #3 Measures and systematic changes put into place to ensure no further re-occurrence The Director of Nursing or Nurse Managers will re-educate current Licensed and Certified Nursing staff including Agency staff, regarding safe and effective techniques for turning and repositioning while providing incontinent care for residents in bed. This education will be completed 3/27/18. This training will occur to new staff in staff orientation and agency orientation before they can care for residents.	

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F 689	Continued From page 24 Review of the most recent quarterly Minimum Data Set (MDS) dated 12/30/17 revealed that Resident #1 was mildly cognitively impaired and required extensive assistance (resident is involved in the activity and staff provides weight bearing support) of 1 staff member with bed mobility and toileting. No falls were reported on the MDS. Review of the Assignment Sheet for the unit where Resident #1 resided revealed that she required extensive assistance of 1 staff member with turning and repositioning. The assignment sheet did not include that Resident #1 was able to assist with turning and repositioning by crossing her right leg over her left leg and reaching for the grab rails that was on the bed. It also did not indicate that Resident #1 should be turned toward staff instead of away from staff. Review of facility document titled Incident/Accident Report dated 02/12/18 at 9:00 PM read in part, Nursing Assistant (NA) #1 was preparing to provide incontinent care to Resident #1. Resident #1 was asked by NA #1 to roll onto her left side, Resident #1 flung her right leg over the left leg propelling her body off the left side of the bed onto the floor. The report was signed by the Director of Nursing (DON). Review of the local hospital ER report dated 02/13/18 read in part, that Resident #1 reported a fall at the facility and complained of left flank pain and swelling. Upon evaluation the MD indicated that Resident #1 had soft tissue swelling and ecchymosis (discoloration of the skin that resulted from bleeding underneath) right mid lower leg and soft tissue swelling with tenderness, induration, and ecchymosis to the left lower	F 689	#4 Corrective actions will be monitored to ensure there are no further occurrences The Director of Nursing and Nursing Managers will monitor 10 NAs weekly for 12 weeks, on varying shifts, to observe care provided to residents remaining in bed during incontinent care. These observations will validate safe and effective techniques for turning and repositioning are utilized. Opportunities will be corrected as identified. The DON will report the results of these audits and monitoring to the weekly Ad Hoc QAPI committee meeting for 12 weeks and then monthly for 3 months #5 Date of alleged compliance March 27, 2018	

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abdomen consistent with probable subcutaneous hematoma.

Review of a Computed Tomography (CT) of the abdomen that was completed in the ER on 02/13/18 confirmed that Resident #1 had a subcutaneous hematoma with active extravasation (leaking of fluid).

An interview was conducted with Nursing Assistant (NA) #1 on 02/26/18 at 2:24 PM. NA #1 confirmed that she was caring for Resident #1 on 02/12/18 for the first time. She stated she had entered Resident #1's room at 9:00 PM to provide incontinent care to Resident #1. NA #1 stated that she was on the right side of the bed and instructed Resident #1 to turn onto her left side and NA #1 grabbed a hold of the pad, Resident #1 took her right leg and flung it over her left leg and it propelled her body off the left side of the bed onto the floor. NA #1 stated she immediately asked Resident #1 if she was ok and she replied that she was not ok and to get her out of the floor. She added that Resident #1 was lying on her back partially under the bed and was complaining of pain and stated "my ribs are broken." NA #1 added that Resident #1 kept saying that she needed to go to the hospital. She added that Mediation Aide (MA) #1 was in the room at the same time administering medications to Resident #1's roommate. MA #1 heard the fall and went to summon Nurse #2. NA #1 stated that she was not aware that Resident #1 flung her right leg over the left until after the fall when NA #2 told her "you have to watch for that." She was also not aware that she should turn Resident #1 towards her instead of away from her. NA #1 stated that it happened so quickly she had no time to reach out and even grab for Resident #1. NA #1 stated that

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Resident #1 was positioned down towards the end of the bed so the grab bar was not even there to slow her down as she propelled herself out of the bed. NA #1 stated that by the time she completed walking rounds at the end of her shift Resident #1 was resting quietly in her bed.

An interview was conducted with MA #1 on 02/26/18 at 2:44 PM. MA #1 confirmed that she was working on the unit where Resident #1 resided on 02/12/18. MA #1 stated that she had entered Resident #1's room at approximately 9:00 PM to medicate her roommate while NA #1 provided care to Resident #1. MA #1 stated that she heard NA #1 ask Resident #1 to turn onto her left side and then heard Resident #1 fall to the floor. MA #1 stated that she went out to the hallway and motioned for Nurse #2 to come to the room. She stated Nurse #2 entered Resident #1's room and observed her on the floor. She stated that Resident #1 was transferred with the mechanical lift from the floor back to bed. She added that Resident #1 was crying and complaining of pain and wanted to go to the hospital. MA #1 stated that she would tell Nurse #2 again that she wanted to go to the hospital but that was a call she could not make.

An interview was conducted with Nurse #2 on 02/26/18 at 3:37 PM. Nurse #2 confirmed that she was working on 02/12/18 and was working on the unit where Resident #1 resided. She stated that at approximately 9:00 PM she was alerted that Resident #1 was on the floor. Nurse #2 stated that she entered Resident #1 s room and NA #1, NA #2, and MA #1 were all in the room. She stated that Resident #1 was requesting to get off the floor. Nurse #2 stated that Resident #1 stated something but she could not recall what it

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was but it was nothing that was concerning to her. She added she did not hear Resident #1 request to go to the hospital. Nurse #2 stated that she waited until the 3 staff members transferred Resident #1 off the floor to the bed and exited the room. Nurse #2 did not assess Resident #1 at the time of the fall because Nurse #2 assumed that MA #1 would completed the assessment and notify the Medical Doctor (MD).

An interview was conducted with NA #2 on 02/26/18 at 3:02 PM. NA #2 confirmed that she routinely cared for Resident #1 on day shift. She added that on the evening of 02/12/18 she was working over on the unit but was not responsible for Resident #1 that evening. NA #2 stated that at approximately 9:00 PM MA #1 stated "I need your help to get Resident #1 up off the floor." NA #2 stated that she went and got the lift and entered Resident #1's room. She stated that when she entered Resident #1's room her bed was elevated and Resident #1 was lying on her back under the bed. NA #2 stated that Resident #1 stated "get me off the floor I broke my ribs and get me to the hospital." NA #2 stated that they used the lift and assisted Resident #1 back to bed and NA #1 finished providing incontinent care to her. She added that Resident #1 was very adamant that she wanted to go to the hospital even when Nurse #2 was in the room. NA #2 stated that MA #1 stated to Resident #1 that she could not make the call to send her to the ER but would again let Nurse #2 know that she wanted to go. NA #2 stated that it was routine for Resident #1 to fling her right leg over her left leg that was how she assisted with turning and repositioning. NA #2 stated that she took care of her so often that she was used to watching for that because Resident #1 would very swiftly fling her right leg over her

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left leg. NA #2 stated she knew to watch for that and that was how she kept Resident #1 safe in her bed.

A follow up interview was conducted with NA #2 on 02/28/18 at 5:46 PM. NA #2 again confirmed that she routinely provided care to Resident #1 and during bed mobility NA #2 rolled Resident #1 towards her instead of away from her, because she kicks her right leg up and over the left leg. NA #2 stated that she did not share that information with NA #1 because she was not aware that was the first time that NA #1 had provided care to her. NA #2 stated she would have told NA #1 during walking rounds if she knew that NA #1 had never cared for Resident #1.

A review was conducted of a Situation, Background, Assessment, and Recommendation (SBAR) dated 02/13/18 at 1:56 AM that was completed by Nurse #1. The SBAR indicated that Resident #1 complained of pain and when questioned where she was hurt she stated she had broken ribs and her right leg hurt. Nurse #1 inquired how she got hurt and Resident #1 stated that "she got thrown onto the floor by the day staff and thrown back into bed." Resident #1's vital signs were: blood pressure: 194/78, pulse: 100, respirations: 20, and temperature: 96.9. The SBAR indicated that Resident #1 had decreased mobility and had pain when moved side to side or moved her right leg. The SBAR further indicated that Resident #1 was experiencing abdominal pain and distention. Nurse #1 indicated that Resident #1 had a distended left lower rib area and left upper abdominal area and also purple bruise to left lower leg. Resident #1 was complaining of pain to both areas. The on call MD was contacted and a new order was obtained to

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send the resident to the Emergency Room (ER) for evaluation. EMS was notified at 1:15 AM on 02/13/18 and transported Resident #1 to the ER.

An interview was conducted with Nurse #1 on 02/27/18 at 8:47 AM. Nurse #1 confirmed that she worked 3rd shift on 02/12/18. She stated that on 02/13/18 at approximately 12:30 AM Resident #1 complained of pain. Nurse #1 stated that it was unusual for Resident #1 to complain of pain so she went to her room to find out what was going on. When questioned by Nurse #1 about her pain Resident #1 stated "they broke my ribs when they pushed me out of bed." Nurse #1 stated that upon assessment Resident #1's left lower rib area and left upper abdominal area were distended and hurting her. She added that Resident #1 was not able to rate her pain but requested to go to the hospital. Nurse #1 stated she called the on call MD and notified him of Resident #1's complaints and received an order to send Resident #1 to the ER for evaluation at notified Emergency Medical Services at 1:15 AM. Nurse #1 confirmed that she had received report from Nurse #2 at the beginning of her shift but the report contained nothing about Resident #1's fall.

An observation was made on 02/26/18 at 1:17 PM of NA #3 and NA #4 transferring Resident #1 from chair to bed. Resident #1 was sitting on a lift pad that was then hooked to the mechanical lift via loops at 4 points on the lift pad. Once the loops were attached to the lift Resident #1 was raised up and moved over to her bed, where she was lowered and the lift pad loops removed from the mechanical lift. After the mechanical lift had been removed NA #3 instructed Resident #1 to turn onto her left side, Resident #1 was observed to fling her right leg over the left and reach for the

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F 689	Continued From page 30 grab bar and turn towards NA #4 who was standing on the left side of the bed. The motion of Resident #1 was swift almost reflexive in nature. Resident #1 required assistance from the staff to turn over far enough to remove the lift pad from underneath her. After NA #3 and NA #4 removed the lift pad and provided incontinent care Resident #1 was very emphatic that she be pulled down in the bed towards the foot of the bed, she requested that her head be below the grab bar that she had used to assist in turning onto her left side. NA #4 was observed to pull Resident #1 down towards the end of the bed, it was not far enough down for Resident #1 and she was again pulled down in the bed closer to the foot of the bed per her request. An interview was conducted with the DON on 02/26/18 at 6:06 PM. The DON stated that she had received a call at around 1:00 AM on 02/13/18 from the staff alerting her that Resident #1 had fallen and had a hematoma and had gone to the ER. The DON stated that she obtained statements from the NAs and the MA and discovered that NA #1 was providing incontinent care and asked Resident #1 to turn onto her side and she flung one leg over the other and it caused her to roll out of the bed. She added that MA #1 was in the room medicating Resident #1's roommate and heard the fall and immediately went and got Nurse #2. They eventually got Resident #1 off the floor and back in bed and then later they sent her to the ER. The DON stated that she would have expected the staff to keep Resident #1 as safe as possible and keep her safely in the bed while providing care.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		3/27/18

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F 726	Continued From page 31 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure that an agency nurse was trained and competent before allowing the nurse to care for residents for 1 of 3 agency nurses reviewed (Nurse #2).	F 726	#1 Corrective Action for the resident found to be affected Resident was assessed by the nurse , doctor called and resident sent to the ER	

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F 726	Continued From page 32 Immediate Jeopardy began on 02/12/18 when Resident #1 fell from the bed during incontinent and Nurse #2 did not perform an assessment, did not notify the Medical Doctor (MD), and did not report the fall to the oncoming shift. Nurse #2 was a new agency nurse to the facility and had received no orientation to the facility and received no competency skills check to ensure that she was competent to care for residents in the facility. Nurse #2 was not clear on the delineation of responsibilities to a Medication Aide (MA) and assumed that MA #1 would handle the assessment of Resident #1, the notification of the MD, and report it to the oncoming shift. Immediate jeopardy was removed on 02/28/18 at 6:20 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place for ensuring all staff are trained and competent before caring for residents in the facility. The findings included: Review of the facility contract from Nurse #2's staffing agency dated 06/16/17 read in part, client (the facility) agrees to provide proper orientation for any area within the client's facility to which the healthcare professional (Nurse#2) is assigned, prior to the healthcare profession taking any patient load. Review of Nurse #2's employee file at the facility revealed only a resume, references, and skills checklist that were provided by Nurse #2's	F 726	#2 Corrective action taken for these residents having the potential to be affected On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident□s medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review. #3 Measures and systemic changes put into place to ensure practice does not reoccur On 2/27/18 The Director of Nursing and Nurse Managers re-educated all current Licensed Nurses and Agency Nurses currently working in the facility, regarding the facility policy for Changes in Resident Condition, with a focus on Notification of the Physician following an Incident/Accident. A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit Manager on Duty or the Nurse Manager on Call when a resident has a fall. The Unit Manager on Duty or the Nurse Manager on Call will be listed	

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staffing agency. There was no education, no licensed nurse competency checklist, or orientation material from the facility to indicate that Nurse #2 had received any orientation or competency skills since arriving at the facility for duty on 02/12/18.

An interview was conducted with MA #1 on 02/26/18 at 2:44 PM. MA #1 confirmed that she was working on the unit with Nurse #2 on 02/12/18. MA #1 stated that at approximately 9:00 PM Resident #1 fell and she stepped out in the hall and motioned for Nurse #2 to come to the room. She stated Nurse #2 entered the resident's room and observed her on the floor but completed no assessment. She stated that the Resident #1 was transferred with the mechanical lift from the floor back to bed and at that point Nurse #2 exited the room. MA #1 stated that she was not able to assess Resident #1 that was the responsibility of Nurse #2. MA #1 stated that she had counted the narcotics on the medication cart with Nurse #1 at that end of her shift, but Nurse #2 was responsible for giving report to Nurse #1 about the residents and their condition.

An interview was conducted with Nurse #2 on 02/26/18 at 3:37 PM. Nurse #2 confirmed that she arrived to the facility on 02/12/18 for the first time. She entered the building and was directed to the unit where she would be working. Nurse #2 could not recall who had directed her to the unit. Nurse #2 confirmed that she received report on the unit from Nurse #3 and was told if she had any questions she could ask MA #1 who was working the other end of the unit. Nurse #2 stated she had worked in other states but had never been exposed to working with an MA and was not aware of the things that they could do and could

on the Daily Assignment Sheet along with contact information. This will be posted at each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the Physician was notified as well as making any recommendations for ongoing interventions and treatments.
On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding this new process for notification of the Physician for residents having a fall.
On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a fall or a significant change in condition. This education included that Nurse Aides will immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation.
No agency staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 2/27/18. New Agency and new contracted housekeeping and dietary staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident assignment.
On 2/28/18 a new process was initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of

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F 726	Continued From page 34 not do. Nurse #2 stated that on 02/12/18 at 9:00 PM Resident #1 fell and the staff did notify her of the fall but she assumed that MA #2 would handle the assessment, the MD notification, and report it to the oncoming shift. An interview was conducted with Nurse #3 on 02/27/18 at 1:26 PM. Nurse #3 confirmed that she gave Nurse #2 report on 02/12/18 when she arrived to the unit to work. Nurse #3 stated that she recalled giving Nurse #2 a run down on the residents on the entire unit. She added that with new staff she tried to give them a brief description of how the unit ran and always told them if they had any questions she could ask MA #1 on the unit, she was a good resource for information. Nurse #3 stated that she believed she had given Nurse #2 a good report and directed Nurse #2 to the survival book at the nurse's station. Nurse #3 stated that she informed Nurse #2 general things about the MA that included which part of the unit the MA administered medication too but not specifically what else the MA could do or could not do. An interview was conducted with the Unit Coordinator (UC) on 02/27/18 at 12:53 PM. The UC confirmed that she was responsible for the unit where Nurse #2 worked on 02/12/18. The UC stated that Nurse #3 had given report to Nurse #2 on the residents on the unit and brief over view of how the unit worked and instructed her if she had any questions she could ask MA #1 on the unit. The UC stated she touched based with Nurse #2 before she left for the day and welcomed her to the unit and told her the Administrator was the abuse coordinator and if any issues arose to call the DON and made sure she had the phone number. The UC was not sure why Nurse #2 did	F 726	Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident/Accident reports to validate the following process was completed as implemented: -the Physician was notified of the event -the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed. 4. Yvonne Washburn, LNHA is responsible for implementing this acceptable plan of correction. Data from monitor will be brought to the weekly Ad Hoc QAPI meeting for 12 weeks and than Monthly for 3 months.	

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not receive orientation to the facility and was not aware that she did not know what her responsibilities were if a resident fell.

An interview was conducted with the Area Staff Development Manager (ASDM) on 02/28/18. The ASDM stated that the agency staff should essentially receive the same orientation as the facility's employees would receive. She added that it would be a little less because we would not need all the personal information and immunization paper work like we would for facility employees, their documents would be kept at their prospective agencies. The ASDM stated that each employee including agency should receive general orientation to the facility which included things like abuse/neglect, dementia training, fire safety, grievances, and a tour of the facility. Then the nurses should receive orientation specific to nursing like blood borne pathogens, transfers, mediation pass, and should complete the licensed nurse competency checklist. The ASDM stated that the general orientation was done by her or by someone designated in the facility and the clinical pieces would be done by a nurse in the facility like a unit coordinator or the DON. The ASDM stated that she could not answer why Nurse #2 did not have any orientation or why she was allowed to take a patient load without receiving any of the required education.

An interview was conducted with the Director of Nursing (DON) on 02/16/18 at 6:06 PM. The DON stated that during her investigation of Resident #1's fall that occurred on 02/12/18 she discovered that Nurse #2 had not received the education that she needed prior to her taking the patient load 02/12/18. The DON stated that "it was a system failure on our part" and that since the incident

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they are doing more education with the agency staff that included the delineation responsibilities of the MAs and what they could and could not do. The DON stated that prior to the incident on 02/12/18 the facility had put together a "survival book" at each nursing station but unfortunately Nurse #2 was not oriented to the facility or unit and did know about the survival books that would give her information on what do if a resident fell.

A follow up interview was conducted with the DON on 02/27/18 at 8:34 AM. The DON stated that prior to the incident on 02/12/18 that the facility assumed that the agency staff had a general knowledge of policy and procedures and we found that most of them did not. The DON stated that Nurse #2 "fell through cracks" and with so much agency staff in the building it was hard to keep up with the competency level of staff that changed daily. The DON stated that they realized that they have to do more education then what they had been doing.

An interview was conducted with the Administrator on 02/28/18 at 6:38 PM. The Administrator stated that she expected all staff including agency staff to receive the proper orientation and competency's required prior to assuming care for the residents in the facility.

The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM.

Credible Allegation F726:

1. On February 12, 2018 at approximately

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9:00pm Nurse Aide (NA) #1 entered Resident #1's room to provide incontinent care and Certified Medication Aide (CMA) #1 entered the same room to administer medications to the roommate. Resident #1 requires assistance with bed mobility and while NA #1 was attempting to turn her in the bed her leg "flopped" off the side of the bed causing her to fall to the floor. At 9:05pm CMA #1 left the room to get Agency Nurse #2 and then went to get NA #2 (who gathered the mechanical lift and came to the room). Agency Nurse #2 stated she went to the door and waited until Resident #1 was placed back in bed by NA #2. Agency Nurse #2 explained that she completed no further assessment on Resident #1 after she fell from bed. On February 12, 2018 at 11:00 pm report was given from Agency Nurse #2 to the on-coming Nurse#1, but did not include information regarding this fall. On February 13, 2018 at 1:00am Nurse #1 entered Resident #1's room, at which time Resident #1 was complaining of pain in her left flank area, and reported a fall from the bed several hours earlier. On February 13, 2018 at 1:15am Nurse #1 notified the on call Physician regarding the fall and subsequent assessment of Resident #1, orders were received to send her to the Emergency Room for further evaluation.

A Root Cause analysis was conducted by the Interdisciplinary Team (IDT) on 2/27/18 and it was determined that Agency Nurse #2 was confused regarding the delineation of responsibilities when a Nurse is working with a Certified Medication Aide which resulted in her lack of timely response to the incident that occurred on 02/12/18. Agency Nurse #2 stated that she was not accustomed to working with CMAs and thought CMA #1 was completing the assessment and

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notifying the physician.

The root cause analysis identified that Agency Nurse #2 did not receive orientation or training from the facility regarding a nurse's responsibilities at the facility, including the need to assess a resident and to notify a resident's physician after a resident experienced a fall or a significant change in a condition, prior to beginning her work assignment on 2/12/18 which was her first day working at the facility.

2. Residents receiving care form Agency Nurses may be affected by this alleged deficient practice. On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of current Agency staff to create a list of active Agency Nurses who have worked during the last 30 days. An interview was conducted with these Nurses to discuss the previous orientation process. The Nurse Managers covered the resident assignments to allow for an updated orientation program to be provided by the Area Staff Development Manager on 2/27/18 beginning with 3p-11p shift.

3. On 2/27/18 The Area Staff Development Manager re-educated current Agency Nurses regarding the facility policy for "Changes in Resident Condition", with a focus on assessment after a resident has a fall and Notification of the Physician following a fall.

Licensed Nurses were re-educated regarding the components of a nursing assessment following a fall to include:
-vital signs
-neuro checks when a head injury is suspected, changes in level of consciousness occurs or

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subtle changes in cognition
-check the skin for bruising, abrasions, changes in sensation and deformity
-range of motion of extremities
-evaluate pain for severity and location

A new process was implemented on 2/27/18 requiring the Licensed Nurse to notify the Unit Manager on Duty or the Nurse Manager on Call when a resident has a fall or significant change in condition. The Unit Manager on Duty or the Nurse Manager on Call will be listed on the Daily Assignment Sheet along with contact information. This will be posted at each Nurses Station. The Nurse Manager will review the event with the Licensed Nurse, validate the nursing assessment was completed according to guidelines listed above as well as making any recommendations for ongoing interventions and treatments. The Nurse Managers completed the education for this new process.
On 2/27/18 The Area Staff Development Manager educated current Agency Nurses regarding this new process for assessment of residents after a fall or significant change of condition and notification of the Physician after a resident has a fall or significant change of condition.

No Agency staff shall work after 2/27/18 before receiving this education in addition to the Agency orientation checklist. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 2/27/18.

New Agency staff that have not received training will be required to report for duty 2 hours prior to their shift to receive this education from the Scheduling Nurse prior to accepting a resident

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F 726	Continued From page 40 assignment. On 2/28/18 a new process will be initiated during the morning clinical meeting. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident/Accident reports to validate the following process was completed as implemented. -an Situation Background Assessment Response (SBAR) or Nursing progress note is present to document completion of a nursing assessment as outlined in the guideline. -the Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event -the Physician was notified of the event The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed . 4. The Administrator is responsible for implementing this acceptable plan of correction Immediate jeopardy was removed on 02/28/18 at 6:20 PM when nursing staff interviews revealed that they had received the facility's general orientation and had received the revised policy on what to do if a resident fell or had a change in condition.	F 726		
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.	F 842		3/27/18

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(ii) The facility may release information that is resident-identifiable to an agent only in 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.

§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-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§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-
(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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 42 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document a residents fall in the medical record for 1 of 3 residents sampled for accidents (Resident #1). The findings included: Resident #1 readmitted to the facility on 02/20/18 with diagnoses that included subcutaneous hematoma, history of pulmonary embolism, coronary artery disease, dementia, diabetes mellitus and others. Review of the most recent quarterly Minimum Data Set (MDS) dated 12/30/17 revealed that	F 842	F842 #1 Corrective Action for Resident # 1 Resident record now reflect her fall #2 Corrected action taken for those residents having the potential to be affected All residents who have had a fall have a potential to be affected by this alleged deficient practice. On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with	

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Resident #1 was mildly cognitively impaired and required extensive assistance of 1 staff member with bed mobility and toileting. No falls were reported on the MDS.

Review of facility document titled Incident/Accident Report dated 02/12/18 at 9:00 PM read in part, Nursing Assistant (NA) #1 was preparing to provide incontinent care to Resident #1. Resident #1 was asked by NA #1 to roll onto her left side, Resident #1 flung her right leg over the left leg propelling her body off the left side of the bed onto the floor. The report was signed by the Director of Nursing (DON).

Review of Resident #1's medial record on 02/26/18 revealed no documentation of the fall that occurred on 02/12/18 at 9:00 PM.

An interview was conducted with Nursing Assistant (NA) #1 on 02/26/18 at 2:24 PM. NA #1 confirmed that she was caring for Resident #1 on 02/12/18. She stated she had entered Resident #1's room at 9:00 PM to provide incontinent care to Resident #1. NA #1 stated that she had instructed to Resident #1 to turn onto her left side and grabbed a hold of the pad, Resident #1 took her right leg and flung it over her left leg and it propelled her body off the left side of the bed onto the floor. NA #1 stated she immediately asked Resident #1 if she was ok and she replied that she was not ok and to get her out of the floor. NA #1 stated that Mediation Aide (MA) #1 was in the room at the same time administering medications to Resident #1's roommate. MA #1 heard the fall and went to summons Nurse #2.

An interview was conducted with MA #1 on 02/26/18 at 2:44 PM. MA #1 confirmed that she

changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed to identify residents that have fallen during the last 30 days. The resident□s medical record was then reviewed to validate there is Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to the Physician following a fall or significant change. The Nurse Managers completed notification to the Physician for any opportunities identified a result of this review.

#3 Measures and systematic changes put into place to ensure no further re-occurrence
On 2/27/18 The Director of Nursing and Nurse Managers re-educated all current Licensed Nurses and Agency Nurses currently working in the facility, regarding the facility policy for Changes in Resident Condition, with a focus on Notification of the Physician following an Incident/Accident, on assessment following a fall and completion of documentation as follows:
Licensed Nurses were re-educated regarding the components of a nursing assessment and documentation following a fall to include:
-vital signs
-neuro checks when a head injury is suspected, changes in level of consciousness occurs or subtle changes in cognition
-check the skin for bruising, abrasions,

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was working on the unit where Resident #1 resided on 02/12/18. MA #1 stated that she had entered Resident #1's room at approximately 9:00 PM to medicate her roommate while NA #1 provided care to Resident #1. MA #1 stated that she heard NA #1 ask Resident #1 to turn onto her left side and then heard Resident #1 fall to the floor. MA #1 stated that she went out to the hallway and motioned for Nurse #2 to come to the room. She stated Nurse #2 entered Resident #1's room and observed her on the floor. She stated that after Resident #1 was transferred back to bed Nurse #2 exited the room.

An interview was conducted with Nurse #2 on 02/26/18 at 3:37 PM. Nurse #2 confirmed that she was working on 02/12/18 and was working on the unit where Resident #1 resided. She stated that approximately 9:00 PM she was alerted that Resident #1 was on the floor. Nurse #1 stated that she entered Resident #1's room and NA #1, NA #2, and MA #1 were all in the room. She stated that Resident #1 was requesting to get off the floor. Nurse #2 stated that she waited until the 3 staff members transferred Resident #1 off the floor to the bed and exited the room. She stated that she assumed that MA #1 would document the fall in Resident #1's medical record. Nurse #2 confirmed that she did not document the fall in Resident #1's medical record.

An interview was conducted with the DON on 02/26/18 at 6:06 PM. The DON stated that when she became aware of the fall she spoke with Nurse #2 and realized that she was not familiar with MAs and what they could and could not do. The DON stated that she expected that Nurse #2 would have documented the fall it the medical record. The DON stated that MAs are not able to

changes in sensation and deformity
-range of motion of extremities
-evaluate pain for severity and location
-an Situation Background Assessment Recommendation (SBAR) or Nursing progress note is complete to document the nursing assessment as outlined in the guideline
On 2/28/18 a new process will be initiated during the morning clinical meeting. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident/Accident reports to validate the following process was completed as implemented.
-an Situation Background Assessment Recommendation (SBAR) or Nursing progress note is present to document completion of a nursing assessment as outlined in the guideline.
-the Director of Nursing and Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event.
-Recording falls has been included in the orientation of all new facility staff and agency staff as of March 27, 2018.

4. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting for 12 weeks then monthly for 3 months and the committee will make recommendations as needed.

#5 Date of alleged compliance March 27, 2018

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	345128	A. BUILDING _____ B. WING _____	C 02/28/2018

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BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	**520 VALLEY STREET STATESVILLE, NC 28677**

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F 842	Continued From page 45 document falls or change of condition in the medical record that was the responsibility of the nurse.	F 842		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §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: §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; §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 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/27/18

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

Electronically Signed | 03/23/2018

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F 880	Continued From page 1 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 observations, record reviews, and staff interviews the facility failed to have hand washing supplies available and to perform proper hand washing during a wound observation of a resident that was on Enteric precautions for clostridium difficile colitis (C-Diff) for 1 of 1 observed residents on isolation precautions (Resident #3). The findings included: Review of facility fact sheet for Clostridium	F 880	PLAN OF CORRECTION FOR 2567 on March 15, 2018 F880 SS=D #1: Corrective Action for the resident found to be affected by the alleged deficient practice: Resident #3 had soap and paper towels stocked in her room, on February 27, 2018, by the HSG Environmental Services Supervisor and	

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F 880	Continued From page 2 Difficile (C-diff) revised in 2017 read in part, extend contact precautions to 48 hours after diarrhea is resolved. Special considerations read in part, wash hands with soap and water. Do not use an alcohol hand rub. Alcohol based hand rubs are not effective in killing C-Diff. Review of a physician order for Resident #3 dated 01/12/18 read in part, clean stage 4 pressure ulcer to coccyx with wound cleaner, pat dry with gauze, apply silver alginate (antimicrobial wound product), and cover with border gauze every day. Review of a physician order for Resident #3 dated 02/10/18 read, contact precautions for C-Diff. An observation was made of Resident #3's door on 02/27/18 at 11:00 AM. The door contained a sign that read, Contact Precautions then under it stated Enteric precautions: Perform hand hygiene before entering room or cubicle and wash hands with soap and water for 15 seconds before leaving the room. The sign also indicated that gloves were required when entering the room and a gown was required for direct patient care or whenever clothing may contact surfaces in the room. An observation of wound care was made on 02/27/18 at 11:05 AM. The facility's Wound Nurse (WN) was observed to enter Resident #3's bathroom to wash and dry her hands. The WN used the soap dispenser on the wall and pressed the dispenser 2 times and clear gel emerged into her hand. The WN rubbed her hands together no suds formed and ran them under the water. She shook the excess water off her hands and reached for a paper towel to dry her hands and there was no paper towels available for use in the	F 880	was verified by the DON. The Nurse and RCS were retrained regarding hand hygiene techniques and to immediately report to the DON or Nurse Managers if hand hygiene supplies are unavailable. Based on the IPCP criteria for contact precautions, specifically C-Diff precautions, Resident #3 was removed on March 3, 2018, as she no longer met criteria. #2: Corrective action taken for those residents having the potential to be affected by the same alleged deficient practice: There are currently no residents on contact precautions to be affected by the alleged deficient practice of proper hand washing with residents on contact precautions. However a 100% audit of all resident rooms and resident care areas was conducted to validate soap, paper towels and hand sanitizer was available. The HSG Environmental Services Supervisor and Regional Supervisor conducted this house wide audit. It was then verified by the DON and Nursing Leadership staff. Any opportunity identified was corrected immediately. #3: Measures and systemic changes put into place to ensure the alleged deficient practice does not re-occur: The housekeeping staff will be re-educated on daily monitoring and refilling of hand hygiene supplies on March 22, 2018 by the SPICE Certified Staff.	

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F 880	Continued From page 3 bathroom. The WN held her hands up and walked across the hall to a common room and obtained paper towels to dry her hands. The WN then reentered Resident #3's room and applied a gown and gloves and went to her bedside to perform wound care. She stated that Resident #3 was on Enteric Precautions for C-Diff and she had just had a loose stool and had been cleaned up by the staff and the old dressing removed. Resident #3 was observed to turn onto her left side, the WN cleaned the large wound to her coccyx with wound cleaner. The WN then removed her gloves and without washing her hands applied new gloves. She then applied the silver alginate and covered the wound with a border gauze. After the new dressing was in place the WN removed her gloves and proceed to the bathroom in Resident #3's room to remove her gown and wash her hands. The WN used the soap dispenser on the wall and pumped it 2 times into her hand. Again a clear gel emerged, she rubbed her hands together no suds formed and again reached for a paper towel to dry her hands. There was no paper towel available for use in the bathroom . The WN again held her hands up and exited the room and walked across the hall to a common area and obtained paper towels to dry her hands. An interview was conducted with the WN on 02/27/18 at 11:15 AM. The WN stated that she had been responsible for the wound program at the facility since November 2017. The WN stated that the clear gel that she used to wash her hands with in Resident #3's room "looked funny" to her and she thought maybe it was hand sanitizer. The WN stated that while performing wound care she had been instructed to wash her hands with soap and water before and after the	F 880	All nursing staff was re-educated on hand hygiene techniques and reporting of missing supplies and correction by the SPICE certified staff by March 27, 2018. Infection Control has been included in the orientation of all new staff including housekeeping and agency staff as of March 27, 2018. A SPICE Certified Staff Member trained each department The Infection Prevention and Control Program (IPCP) will be reviewed by the SPICE certified staff and they will update the program, as necessary. #4: Corrective actions will be monitored to ensure the alleged deficient practice will not re-occur. NHA and Housekeeping Supervisor will monitor 10 resident rooms per Nursing Unit weekly for 12 weeks to validate supplies are readily stocked and available. DON and Nurse Managers will randomly observe 10 facility staff members from varying shifts weekly for 12 weeks to validate hand hygiene techniques. All findings will be recorded on the provided audit form and given to the DON/Administrator to be reviewed and presented at monthly QAPI. QAPI will make further recommendations as needed based on any findings. #5: Date of alleged compliance: March 27, 2018	

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F 880	Continued From page 4	F 880		

treatment. She indicated that she had not been instructed to wash her hands between removing the old dressing and applying a new dressing and there was no difference in her method if the resident was on isolation. The WN again confirmed that she had not been informed that if a resident was on isolation for C-Diff that she needed to wash her hands after she removed the soiled dressing and before applying a clean dressing. The WN stated that the bathroom room should have had soap in the dispenser and not hand sanitizer and paper towels should have been available so she could have properly washed and dried her hands.

An interview was conducted with the Director of Housekeeping (DOH) on 02/27/18 at 11:18 PM. The DOH confirmed that Resident #3's bathroom contained hand sanitizer instead of soap and no paper towels were available to the staff to wash and dry their hands. The DOH stated that he was not sure who put the hand sanitizer in the dispenser but added that it should have been hand soap. The DOH stated he would immediately put soap and paper towels in Resident #3's bathroom.

An interview with House Keeper #1 was conducted on 02/27/18. House Keeper #1 confirmed that she was working the hall where Resident #3 resided but she had not put the hand sanitizer in her bathroom. House keeper #1 stated that it should have been hand soap in the dispenser and there should have been paper towels in the bathroom so staff could adequately wash and dry their hands.

An interview was conducted with the Infection Control Nurse (ICN) on 02/27/18 at 11:56 AM.

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F 880	Continued From page 5	F 880		

The ICN stated that was responsible for overseeing the infection control program at the facility and that included isolation rooms. She stated that Resident #3 would stay on isolation until she had formed stool and she was noted to have a loose stool earlier on the shift so the precautions remained in effect. She stated that with C-Diff the staff was expected to wash their hands with soap and water before and after providing care. The ICN also stated that she would have expected the WN to wash her hands after she removed her gloves after cleaning the wound and before applying a clean dressing to Resident #3. She added that there should have been soap, water, and paper towels in Resident #3's bathroom so the staff could wash their hands as directed by the sign on the door.

An observation of Resident #3's bathroom was conducted on 02/27/18 at 5:21 PM. The observation revealed that soap had been placed in the dispenser but there was no paper towels in the bathroom available for use.

An interview was conducted with the Director of Nursing (DON) on 02/28/18 at 6:38 PM. The DON stated that she expected the WN to wash her hands with soap and water before and after providing wound care, and after she had cleaned the wound and before applying a clean dressing. The DON added that she fully expected that there be soap, water, and paper towels available for use in Resident #3's bathroom and any room that was on isolation precautions.