

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345351</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/10/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN CARE OF SALUDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 ESSEOLA CIRCLE</b> <b>SALUDA, NC 28773</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554 SS=D	<p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations, staff, and physician interviews the facility failed to assess the ability of a resident to safely inject insulin and obtain a physician's order for self-administration of medications for 1 of 1 resident reviewed for insulin administration (Resident #37).</p> <p>Findings Included:</p> <p>Resident #37 was admitted to the facility 09/11/17 with diagnoses which included diabetes mellitus (high blood sugar levels in the body) and long term insulin (a chemical substance produced in the body that regulates blood sugar levels) use.</p> <p>A review of the quarterly Minimum Data Set dated 06/29/18 assessed Resident #37 to be cognitively intact. The assessment of medications identified insulin injections were given for 7 days during the look back period of the assessment.</p> <p>The care plan last reviewed 07/02/18 identified the risk for hypoglycemia (low blood sugar levels) and hyperglycemia (high blood sugar levels) episodes related to the diagnoses of diabetes. The goal was to be free of signs and symptoms of hypoglycemia and hyperglycemia through the next review. The interventions included medications as ordered, blood sugar checks per physician orders and as needed for symptoms of hypoglycemia and hyperglycemia.</p>	F 554	<p>F554- Resident Self Admin Meds-Clinically Appropriately The plan of correcting cited deficiency of F554 and the processes that lead to the citation;</p> <p>The right to self-administer medications if the interdisciplinary team as defined by 483.21 (b) (2) (ii), has determined this practice is clinically appropriate. This requirement is not met as evidence by: Based on record review, observations, staff and physician interviews the facility failed to assess the ability of a resident to safely inject insulin and obtain a physician's order for self-administration of medication and monitoring resident to safely inject insulin.</p> <p>The procedure for implementing the plan of correction for F554;</p> <ol style="list-style-type: none"> <li>On 8/8/18 a self-administration of medication was conducted and a physician's order was obtained so that the resident # 37 could safely administer his insulin injection</li> <li>On August 27, 2018 the IDT team met to identify any other potential residents who may be appropriate for</li> </ol>	9/7/18

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

TITLE

(X6) DATE

Electronically Signed

08/29/2018

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

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F 554	<p>Continued From page 1</p> <p>During an observation on 08/07/18 at 4:37 PM, Nurse #4 preformed hand hygiene, donned gloves, used an alcohol swab to sanitize the top of a lispro insulin vial and withdrew 6 units in an insulin syringe. She explained to Resident #37 it was time for her to check blood sugar levels and administer insulin. After checking the blood sugar, Nurse #4 handed the syringe of insulin to Resident #37 who self-administered the insulin in the lower left abdominal area.</p> <p>A review of Resident #37's most current physician orders for insulin included Lispro (fast-acting insulin) inject 6 units two times a day related to diabetes mellitus. Check blood sugar levels two times a day for diabetes. Insulin Glargine (long-acting insulin) inject 30 units one time a day. No physician's order was found in the medical record for Resident #37 to self-administer insulin.</p> <p>The facility policy named, "Self-Administration of Medication" last revised 05/16 read in part; criteria must be met to determine if the resident is both mentally and physically capable of self-administering medications and to keep accurate documentation of administering the medications. The procedure included verify physician's order in the resident's chart for self-administration of specific medications under consideration. Complete the self-administration of medication assessment form with the resident. The interdisciplinary team would review the assessment and document their findings. If the interdisciplinary team has determined the resident safe to administer medication(s), administration of medication(s) will be care planned for approved self-administered medication.</p>	F 554	<p>self-administration of medication</p> <p>3. A mandatory in-service for all nursing staff on resident self-administration of medications will be held on August 30, 2018</p> <p>4. IDT will review all new admissions for appropriateness of self-administration of medications at weekly meeting.</p> <p>5. The DON or designee will conduct the self-administration of medications assessment in PCC for any resident who is identified as appropriate.</p> <p>6. The DON or designee will obtain, and process the provider order for any resident who has been identified, assessed and identified as safe for self-administration of medications</p> <p>7. The DON or designee will inform and educated the RN/LPN/Medication Aide of any resident that has been assessed and identified as safe for self-administration of medications.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following;</p> <p>1. The DON or designee will complete a weekly audit identifying any resident that is identified by the ADT as potentially appropriate for safe self-administration of medication.</p>		

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F 554	<p>Continued From page 2</p> <p>Self-administration of medications must be reviewed by the interdisciplinary team with each quarterly review, and when a change in status is noted.</p> <p>After reviewing assessments for Resident #37, no self-administration of medication assessment was located in the medical record.</p> <p>During an interview on 08/08/18 at 2:08 PM, the Medical Director (MD) explained his expectations were for the facility to provide a self-administration medication assessment before an a physician's order could be obtained and before Resident #37 could be consider safe to self-administer insulin.</p> <p>During an interview on 08/08/18 at 3:02 PM, the Director of Nursing explained it was her expectation Resident #37 would be assessed by a nurse for self-administration of medication. The assessment would be reviewed to ensure the resident is safe to self-administer the medication and if the MD agreed an order would be obtained.</p> <p>During an interview on 08/09/18 at 3:24 PM, Nurse #4 noted Resident #37 did not have a self-administration medication assessment in the medical record. She explained a self-administration order from the MD was necessary and the resident shouldn't be administering insulin without an order. Nurse #4 explained Resident #36 would not let her administer the insulin and that's why she gave him the syringe. She indicated she would inform the Unit Manager and implement the facility's policy related to self-administration of medications.</p>	F 554	<p>2. The DON or designee will conduct the self-administration of medications assessment in PCC for any resident who is identified as appropriate.</p> <p>3. The DON or designee will obtain, and process the provider order for any resident who has been identified, assessed and identified as safe for self-administration of medications.</p> <p>4. The DON or designee will inform and educated the RN/LPN/Medication Aide of any resident that has been assessed and identified as safe for self-administration of medications.</p> <p>5. The DON will maintain a log of all residents who have been identified and assessed as safe in self administration of medications in her office.</p> <p>6. The DON will be responsible for conducting a self-medication administration assessment and observe the resident self-administer medications quarterly.</p> <p>Results will be reported to monthly QAPI meeting.</p> <p>The person responsible for implementing the plan of correction</p> <p>The DON is responsible for implementing and monitoring the corrective action.</p> <p>The date of compliance is 09/07/18</p>		

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

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F 584 F 584 SS=E	Continued From page 3 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting levels in all areas;  §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584 F 584		9/7/18	

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F 584	Continued From page 4 81°F; and  §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and store resident care items in a sanitary manner and address maintenance concerns in 5 of 14 shared bathrooms on 2 of 5 halls and 2 of 14 rooms on 1 of 5 halls.  The findings included:  1. From 08/06/18-8/10/18 the following concerns were identified in rooms on the D hall of the facility: -On 08/06/18 at 9:52 AM a bedspread was observed under the heat pump in room D9. The resident was in the room at the time of the observation and reported the bedspread was placed under the unit by staff because the heat pump had been leaking. -On 08/06/18 at 10:34 AM the toilet paper holder in the shared bathroom between D5-D7 was observed loosely affixed to the wall. Two of the three residents residing in rooms D5 and D7 used the shared bathroom. -On 08/06/18 at 10:39 AM in room D7 (unoccupied bed) the headboard and footboard were observed tilted inward at an approximate 20 degrees off of vertical. The headboard and footboard were loose at the frame and easily manipulated. -On 08/07/18 at 9:03 AM and 4:30 PM the toilet paper holder in the shared bathroom between D5-D7 remained loosely affixed to the wall. -On 08/07/18 at 4:30 PM there was no toilet	F 584	F584  1.The plan for correcting the specific deficiency. The plan will address the processes that lead to the deficient practice. Process that lead to deficient practice were inclusive of multiple variables. The facility had recently started making a change in Environmental leadership staff and is activity recruiting a qualified Environmental Director. The new Environmental Director begins work 8/29/18.  Administrator has been educating and implementing improved processes with Maintenance Director on active room rounding, assessments, repairs and replace as needed. Lack of consistent room monitoring by Department Heads led to the deficient practice as well.  For immediate plans to correct, the Administrator, Maintenance Director and Director of Nursing rounded and removed all non-labeled resident personal items, basins, urine specimen hats and assured remaining were labeled and stored in a sanitary manner. Labeling and Storage in a sanitary manner to be completed by 8/31/18. Maintenance Director assessed all D Hall Rooms and A Hall Rooms for Heat Pump Issues, Toilet Paper Rolls,		

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F 584	Continued From page 5 paper holder in the shared bathroom between D1 and D3. A roll of toilet paper was observed stored on the hand rail in the bathroom. One of three residents residing in rooms D1 and D3 used the shared bathroom. -On 08/07/18 at 4:30 PM in room D7 (unoccupied bed) the headboard and footboard were observed to remain tilted inward at an approximate 20 degrees off of vertical. The headboard and footboard were loose at the frame and easily manipulated. -On 08/09/18 at 3:00 PM there remained no toilet paper holder in the shared bathroom between D1 and D3. A roll of toilet paper was observed stored on the hand rail in the bathroom. -On 08/09/18 at 3:05 PM the toilet paper holder in the shared bathroom between D5-D7 remained loosely affixed to the wall. In addition, an unmarked, uncovered toothbrush was laying directly on the lid of the commode tank. -On 08/09/18 at 3:06 PM in room D7 (unoccupied bed) the headboard and footboard were observed to remain tilted inward at an approximate 20 degrees off of vertical. The headboard and footboard were loose at the frame and easily manipulated. -On 08/09/18 at 3:10 PM a visibly wet bedspread was observed under the heat pump in the room D9. -On 08/10/18 at 1:30 PM the Maintenance Director stated there was a notebook located at each nurses station for staff to write down any maintenance concerns. In addition, the Maintenance Director stated a manager was assigned to each resident room and was supposed to make a daily round of the room and bathroom and report any maintenance concerns to him. The Maintenance Director stated he depended on staff to report any concerns	F 584	Head Boards/Foot Boards and all repaired and/or replaced by 8/31/18.  2. Process for implementing acceptable POC- Administrator in- serviced all Department Heads on performing Customer Service Rounds to identify any deficiencies as indicated in 2567 occurred on 8/22/18. Administrator implemented revised Customer Service Rounds with Department Heads assigned certain rooms to be completed daily Monday-Friday. This is inclusive of all resident rooms and bathrooms.  3. Monitoring procedure to ensure plan of correction is effective and deficiency remains in compliance. The Maintenance Director will round facility weekly to check for deficiencies cited in the 2567 and will also review the Maintenance work order log daily to ensure repairs are made in a timely manner. The Customer Service Rounds will remain in effect by department heads five days per week. The Administrator will review audits and report findings at QAPI and adjust action plans as indicated.  4. Title of person responsible for implementing POC - <input type="checkbox"/> Administrator.  5. Date of Corrective Action completed: 9/7/18		

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F 584	<p>Continued From page 6</p> <p>because he could not tour each room every day. At the time of the interview the concerns identified 08/06/18-08/09/18 on D hall were reviewed with the Maintenance Director and included:</p> <ul style="list-style-type: none"> <li>-The Maintenance Director verified there was not a toilet paper holder in the shared bathroom between rooms D1-D3. The Maintenance Director stated he was not aware of it and noted there should be a toilet paper holder in each bathroom.</li> <li>-The Maintenance Director stated he was not aware the toilet paper holder was loosely affixed to the wall in the shared bathroom of D5-D7. When the toilet paper was touched, the holder fell off the wall. The Maintenance Director stated he should have been told about the toilet paper holder because it could be easily repaired.</li> <li>-The Maintenance Director stated he wasn't aware the headboard and footboard were loose at the frame in the unoccupied bed in room D7. The Maintenance Director stated he tried to inspect all beds annually and depended on staff to report any concerns between those inspections.</li> <li>-The Maintenance Director stated he wasn't aware the heat pump in room D9 was leaking. The Maintenance Director pulled the cover off the heat pump and noted the coils were frozen and stated it could have contributed to the problem.</li> </ul> <p>On 8/10/18 at 1:45 PM the Director of Nursing observed the unmarked, uncovered toothbrush stored directly on the lid of the commode tank in the shared bathroom between rooms D5-D7. The Director of Nursing stated a resident's toothbrush should never be stored on the lid of a commode tank and it was immediately discarded.</p> <p>On 08/10/18 at 3:53 PM the Administrator stated</p>	F 584			

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F 584	<p>Continued From page 7</p> <p>managers are assigned rooms to round Monday-Friday and he expected any concerns to be reported to the Maintenance Director so repairs could be addressed.</p> <p>2. a. Observations of the shared bathroom for room A1 on 08/07/18 at 9:18 AM revealed 3 unlabeled and uncovered wash basins nesting inside the other with 2 unlabeled and uncovered urine specimen hats stacked inside of the top wash basin. The wash basins and urine specimen hats were placed on the floor of the bathroom in the corner between the wall and toilet.</p> <p>Subsequent observations on 08/07/18 at 3:53 PM, 08/08/18 at 9:31 AM, and 08/09/18 at 3:35 PM revealed the conditions remained unchanged.</p> <p>b. Observations of the shared bathroom for room A3 on 08/07/18 at 9:25 AM revealed an unlabeled and uncovered urine specimen hat placed upside down on the bathroom floor in-between the wall and toilet and an unlabeled and uncovered wash basin sitting on top of the toilet tank.</p> <p>Subsequent observations on 08/08/18 at 9:33 AM, 08/08/18 at 4:10 PM and 08/09/18 at 3:35 PM revealed the conditions remained unchanged.</p> <p>c. Observations of the shared bathroom for room A12 on 08/07/18 at 9:35 AM revealed 2 unlabeled and uncovered wash basins nesting inside the</p>	F 584			

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F 584	Continued From page 8 other placed on the floor in-between the wall and toilet. Further observation revealed an emesis (action or process of vomiting) basin containing 6 unlabeled, disposable razors and 2 unlabeled cans of shaving cream sitting on the shelf above the sink.  Subsequent observations on 08/07/18 at 3:53 PM, 08/08/18 at 9:42 AM and 08/09/18 at 3:35 PM revealed the conditions remained unchanged.  During an interview and tour with the Director of Nursing (DON) on 08/09/18 at 4:12 PM she explained personal care equipment such as wash basins, emesis basins and urine specimen hats, should be labeled with the resident's room # and bed location (window or door) to indicate whom the items belonged and individually covered in a plastic bag when not in use. The DON acknowledged the wash basins and urine specimen hats were not covered or labeled and were stored inappropriately. She further indicated the emesis basin containing the disposable razors and cans of shaving cream should have been removed and not stored in the shared bathroom. The DON stated it was her expectation that all resident personal care equipment would be labeled, covered and stored appropriately.	F 584			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse,	F 607		9/7/18	

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F 607	<p>Continued From page 9</p> <p>neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on policy and record review, and resident and staff interviews, the facility failed to implement their abuse policy in the area of investigation for 1 of 1 resident who reported an allegation of resident-to-resident abuse resulting in bruising to her arm (Resident #62).</p> <p>Findings included:</p> <p>A review of the facility policy and procedure titled "North Carolina Resident Abuse Policy", with a revised date of 03/03/17, read in part: "It is the facility's policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. 7.b) Investigation protocol: The person investigating the incident should generally take the following actions: i) Interview the resident, the accused, and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the alleged victim the day of the incident; iii) obtain written statements from the resident, if possible, the</p>	F 607	<p>F607</p> <p>The Plan of Correcting the specific deficiency.</p> <p>The original allegation on 6/25/18 for Resident #62 was investigated and a Facility Reportable Incident was submitted by the administrator. The area of concern identified is that the facility failed to implement their abuse policy and failed to complete a thorough investigation as evidenced by undated and unsigned summary of investigation, lack of written statements from the alleged victim, alleged perpetrator, witnesses or staff working at the time of the alleged incident, lack of occurrence documentation and lack of skin assessment at the time of the allegation.</p> <p>1. An investigation was conducted by the Administrator and Director of Nursing. A 24-hour Facility Reportable Incident was submitted on 06/25/18 and 5 Day report was submitted on 06/29/18.</p> <p>2. The Police were notified of the incident on 06/25/18 and no charges filed.</p>		

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F 607	<p>Continued From page 10</p> <p>accused, and each witness. 7.c) Documentation: evidence of the investigation should be documented."</p> <p>Resident #62 was admitted to the facility on 02/28/18 with diagnoses that included dementia, anxiety disorder and major depression.</p> <p>Review of the facility's abuse investigation completed by the Interim Director of Nursing (IDON) revealed the facility was notified of the allegation of abuse by Resident #62 on 06/25/18. The documentation of the investigation included: An undated and unsigned summary of the investigation which included a recap of interviews conducted with the alleged victim, perpetrator and another resident who witnessed the event. Copies of the 24-hour and 5-day reports completed and submitted to the State Agency. It was noted on the reports that police were notified on 06/25/18. An undated Resident-to-Resident Tool form completed which indicated the date of the alleged abuse occurred on 06/24/18. There was no copy of the police report or signed, written statements from the alleged victim, the alleged perpetrator, witnesses to the incident, or staff working at the time of the alleged incident.</p> <p>Review of the facility's Incidents by Incident Type report revealed no incident report was completed for Resident #62 related to the allegation of abuse reported on 06/25/18.</p> <p>Review of Resident #62's medical record</p>	F 607	<p>Licensed nursing staff completed a skin assessment on 06/27/18.</p> <p>3. The current leadership was not present at time of the initial allegation and investigation.</p> <p>4. Moving forward the Administrator will ensure that all allegations of abuse are thoroughly investigated as outlined by facility policy and the regulatory requirements.</p> <p>The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.</p> <p>1. All residents have the potential to be affected.</p> <p>2. The facility conducted 100% in-servicing of staff on the facilities Abuse Policy to ensure all abuse allegations are handled properly. Any negative findings will be forwarded to the facility Administrator and DON for proper and thorough investigations.</p> <p>3. To prevent this from recurring the Regional Director of Clinical Services educated the Administrator and DON on properly conducting a thorough investigation.</p> <p>4. The Administrator re-educated department heads on the abuse policy and conducting a thorough investigation. Education will continue annually. New hires will be educated on abuse policy and</p>		

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F 607	<p>Continued From page 11</p> <p>revealed there was no skin assessment completed on 06/25/18 when the allegation of abuse was reported. Further review revealed a skin assessment was completed on 06/27/18 which indicated Resident #62 had purple discoloration on the right forearm measuring 4.0 x 2.6 centimeters (cm) and the left upper arm measuring 8.0 x 11.3 cm and 2.4 x 2.6 cm. There was no onset date for the bruising noted.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 07/12/18 indicated Resident #62 had severe impairment in cognition but was able to make self-understood and understand others.</p> <p>During an interview on 08/06/18 at 11:48 AM Resident #62 recalled Resident #68 grabbed her arm while out in the smoking area of the facility causing it to bruise but was unable to recall the date and time this incident occurred or when she reported it to facility staff. Resident #62 denied attempting to grab the lighter from Resident #68 and was unsure what had caused him to grab her arm.</p> <p>During a phone interview on 08/07/18 at 2:35 PM the Social Worker (SW) revealed her part of the abuse investigation process consisted of interviewing the residents and providing in-service education to staff. She added any staff interviews were usually completed by the DON. The SW recalled Resident #62 reported while out in the smoking area Resident #68 grabbed her arm which caused it to bruise. She interviewed both residents and concluded they got into an argument over a cigarette lighter. She explained</p>	F 607	<p>procedure upon hire.</p> <p>5. The DON educated licensed nursing staff on completing skin assessments timely and accurately.</p> <p>The monitoring procedure to assure the Plan of Correction is achieved and the specific deficiency cited remains corrected and in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance:</p> <p>The Administrator / DON / designee will start abuse questionnaires with residents. The audits will be completed on 3 residents, 3x weekly x4 weeks, then monthly x2.</p> <p>Any negative findings will be addressed immediately by the Administrator or Director of Nursing. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>The facility administrator will review state reportable occurrences weekly x4, then monthly x2 to ensure abuse is properly reported and investigated thoroughly. Any negative findings will be addressed immediately. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>The title of the person responsible for</p>		

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F 607	<p>Continued From page 12</p> <p>Resident #68 grabbed Resident #62's arm when she reached out and attempted to take the lighter. The SW confirmed she gave her documentation related to the investigation to the Administrator once completed.</p> <p>The IDON who investigated the allegation was no longer at the facility and unavailable for an interview.</p> <p>During an interview on 08/09/18 at 4:12 PM the Director of Nursing (DON) revealed she had only been employed at the facility since July 2018 and was not present at the time the allegation of abuse was reported and investigated for Resident #62. The DON reviewed the facility's documentation of the investigation and stated she would have expected for the investigation to have included documentation such as a head-to-toe assessment, written statements of interviews from residents, witnesses and staff working, nurse note related to the incident, and copy of the police report. The DON stated that based on information included in the facility's abuse investigation for Resident #62 she did not feel the investigation was thorough or followed the facility's abuse protocol.</p> <p>During an interview on 08/10/18 at 9:40 AM the Administrator revealed he had only been employed at the facility for a few weeks and did not recall being present when the abuse allegation was reported by Resident #62. He reviewed the documentation included in the facility's abuse investigation for Resident #62 and confirmed the documentation did not indicate a</p>	F 607	<p>implementing the acceptable plan of correction is the Administrator and/or Director of Nursing.</p> <p>Date of Alleged Compliance is: 09/07/18</p>		

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F 607	Continued From page 13 thorough investigation was conducted. The Administrator stated he would expect for all allegations to be thoroughly investigated and the abuse policy followed as a guideline for the investigation.	F 607			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 636		9/7/18	

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F 636	<p>Continued From page 14</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to complete a Care Area Assessment (CAA) that accurately assessed and addressed the triggered area of pressure ulcers for 1 of 1 sampled residents reviewed with wounds and weight loss. (Resident #29)</p> <p>The findings included:</p>	F 636	<p>F636 Comprehensive Assessments &amp; Timing</p> <p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <p>The area of concern identified on 8/10/2018 a Care Area Assessment (CAA)</p>		

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F 636	<p>Continued From page 15</p> <p>Resident #29 was admitted to the facility 05/22/18 with diagnoses which included dementia.</p> <p>Review of the admission Minimum Data Set (MDS) dated 05/29/18 (with a modification MDS dated 06/04/28) assessed Resident #29 with no wounds.</p> <p>The Care Area Assessment (CAA) for pressure sores associated with the 05/29/18 admission assessment stated, "The resident is alert and is able to verbalize some needs to staff. He is confused and can only follow simple commands. He is extensive to total assist for bed mobility, transfers, dining and toileting. He has a Foley catheter in place and is frequently incontinent of bowel. He has no peri area wounds at this time. He has a diagnosis of psychosis and takes Olanzapine for this. He has a diagnosis of pneumonia and took Doxycycline, Levaquin and Rocephin for this. Will proceed to care plan.</p> <p>A nursing progress note dated 05/22/18 noted Resident #29 had an unstageable pressure sore on his left heel.</p> <p>Review of physician orders noted an order written by the Family Nurse Practitioner dated 05/28/18 to "refer to wound specialist for unstageable left heel." The Family Nurse Practitioner progress note associated with the 05/28/18 order noted a diagnosis of unstageable pressure ulcer of left heel.</p> <p>A Weekly Wound Assessment dated 05/29/18 assessed Resident #29 with an unstageable pressure ulcer on his left heel which measured 4.8 centimeters X 4.7 centimeters and was present on admission to the facility 05/22/18.</p>	F 636	<p>was failed to be completed on triggered area of pressure ulcer on Resident #29. An admission Minimum Data Set (MDS) assessment dated 05/29/18 (with a modification MDS dated 06/04/18) failed to code an unstageable pressure sore noted on left heel, which when coded, triggered a CAA. Documentation within the lookback period of the MDS noted an unstageable pressure sore on left heel.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <p>All new admission residents have the potential to be affected. An audit of all Section M admission MDS completed in the past 30 days from 07/10/18 to 08/10/18 by Director of Nursing (DON). No new negative findings were identified.</p> <p>To prevent this from recurring on 08/24/18 the Regional Reimbursement Specialist educated the MDS nurse on accuracy of assessing and coding Section M of MDS and completing the CAA that addresses triggered wounds.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance the DON will audit Section M on admission MDS 1x week x 4 weeks, then monthly x 1 to ensure that there are</p>		

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F 636	Continued From page 16  On 08/08/18 at 2:08 PM the MDS nurse stated the weekly wound report from 05/28/18 should have been referenced when the 05/29/18 admission MDS and CAA were completed for Resident #29. The MDS nurse provided the 05/29/18 weekly wound report which indicated Resident #29 had an unstageable sore on his left heel which was present on admission to the facility. The MDS nurse stated both the 05/29/18 admission MDS, 06/04/18 modification admission MDS and CAA missed the assessment of the wound. The MDS nurse stated the 05/29/18 and 06/04/18 MDS for Resident #29 should have indicated an unstageable wound at the time of the assessments and been addressed in the pressure sore CAA.  On 08/08/18 at 3:43 PM the Director of Nursing stated she expected the MDS and CAA to be an accurate reflection of a resident's physical status and noted the admission MDS and CAA for Resident #29 should have included the unstageable wound on Resident #29's left heel.  On 08/10/18 the Administrator stated he expected the MDS and CAA to be an accurate reflection of a resident at the time of the assessment.	F 636	no issues related to coding Section M on admission MDS assessments. Any negative findings will be addressed immediately to the administrator and corrected by MDS nurse.  The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement meeting for further review and recommendations.  The title of the person responsible for implementing the acceptable plan of correction is the Administrator and/or the Director of Nursing.  Date of Alleged Compliance is: 09/07/18		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to accurately assess 1	F 641	F641 Accuracy of Assessments	9/7/18	

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F 641	<p>Continued From page 17</p> <p>of 6 sampled residents utilizing the Minimum Data Set (MDS) reviewed for activities of daily living to reflect behaviors (Resident #40), 2 of 2 sampled residents reviewed for MDS discrepancy regarding restraints (Resident #36 and Resident #60), 1 of 1 sampled residents reviewed for nutrition/wounds to reflect pressure ulcer (Resident #29) and 1 of 1 sampled resident reviewed for falls regarding restraints (Resident #65).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Resident #40 was admitted to the facility on 01/05/17 with diagnoses including anxiety disorder and depression.</li> </ol> <p>A review of a nurse's note dated 07/01/2018 revealed Resident #40 was resistant to care and refused services when offered.</p> <p>A review of a Social Worker note dated 07/03/18 indicated Resident #40 refused showers and hygiene care.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated 07/03/18 indicated Resident #40 had not been coded under Section E Behaviors E0800 as having rejection of care.</p> <p>On 08/08/18 at 9:46 AM an interview was conducted with the MDS Coordinator who stated the Social Worker (SW) was responsible for coding Section E Behaviors on Resident #40's quarterly MDS assessment dated 07/03/18. The MDS Coordinator stated during the look back period Resident #40 had experienced behaviors of rejection of care and should have been coded under Section E Behaviors E0800 as Rejection of</p>	F 641	<p>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <p>The areas of concern identified on 8/10/2018:</p> <ol style="list-style-type: none"> <li>Resident #40 refusal of care during lookback period on quarterly Minimum Data Set (MDS) assessment dated 07/03/18 was not coded under Section E Behaviors E0800.</li> <li>Resident #60 on quarterly Minimum Data Set (MDS) assessment dated 07/12/18 coded Section P0100 bed rails used daily as physical restraint. Bed rail assessment dated 06/02/18 indicated that Resident #60 utilized bed rails for assistance and support during care and for bed mobility and had been care planned as an enabler.</li> <li>Resident #36 on quarterly Minimum Data Set (MDS) assessment dated 06/29/18 coded Section P0100 bed rails used daily as physical restraint. Bed rail assessment dated 06/10/18 indicated that bed rails were an enabler for positioning and used to assist from side to side and had been care planned as an enabler.</li> <li>Resident #29 on admission Minimum Data (MDS) assessment dated 05/29/18 (with a modification MDS dated 06/04/18) failed to code an unstageable pressure sore noted on left heel, which when coded, triggered a CAA. Documentation</li> </ol>		

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F 641	<p>Continued From page 18</p> <p>Care-Presence and Frequency as behaviors of this type occurred 1 to 3 days. The MDS Coordinator stated she would have to submit a modification to the quarterly MDS assessment dated 07/03/18 under Section E Behaviors to reflect that Resident #40 had Rejection of Care.</p> <p>On 08/08/18 at 10:03 AM a telephone interview was conducted with the SW who stated she was responsible for coding section E Behaviors on Resident #40's quarterly MDS assessment dated 07/03/18. The SW stated she did not realize that Section E Behaviors E0800 Rejection of Care-Presence and Frequency needed to be coded because Resident #40 had been care planned for rejection of care. The SW stated it was an oversight that she had not coded rejection of care on Resident #40's quarterly MDS assessment dated 07/03/18.</p> <p>On 08/08/18 at 10:12 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 07/03/18 would have been accurately coded under Section E Behaviors E0800 to indicate Resident #40 had rejection of care. The DON stated she expected that a modification of the quarterly MDS assessment dated 07/03/18 would be submitted to accurately reflect Resident #40 had behaviors of rejection of care.</p> <p>On 08/08/18 at 10:29 AM an interview was conducted with the Administrator who stated his expectation was that the quarterly MDS assessment dated 07/03/18 would have been accurately coded under Section E Behaviors E0800 to indicate Resident #40 had rejection of care. The Administrator stated he expected that a</p>	F 641	<p>within the lookback period of the MDS noted an unstageable pressure sore on left heel.</p> <p>5. Resident #65 on admission Minimum Data Set (MDS) assessment dated 06/29/18 coded Section P0100 bed rails used daily as physical restraint. Care Area Assessment (CAA) associated with admission MDS dated 06/29/18 revealed bed rails were used as an enabler for bed mobility.</p> <p>The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <p>All residents have the potential to be affected. An audit of question P0100 on all MDS completed in past 30 days and Section M admission MDS completed in past 30 days from 07/10/18 through 08/10/18 by Director of Nursing (DON).</p> <p>To prevent this from recurring on 08/24/18 the Regional Reimbursement Specialist educated the MDS nurse on accuracy of assessing and coding Section M of MDS and completing the CAA that addresses triggered wounds. On 8/24/18 the Regional Reimbursement Specialist also educated the MDS nurse regarding proper coding of P0100 Bed Rail as a Restraint.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p>		

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F 641	<p>Continued From page 19</p> <p>modification of the quarterly MDS assessment dated 07/03/18 would be submitted to accurately reflect Resident #40 had behaviors of rejection of care.</p> <p>2. Resident #60 was admitted to the facility 02/27/14 with diagnoses which included anxiety and depression.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated 07/12/18 assessed Resident #60 to be cognitively intact. The assessment included the resident's functional status abilities with bed mobility, transfers, and toilet use and indicated extensive assistance was needed. Section P0100 of the MDS assessed bed rails were used daily as a physical restraint.</p> <p>A review of the bed rail assessment dated 06/02/18 indicated the rationale for the use of bed rails was a movement disorder. The assessment identified Resident #60 utilized bed rails for assistance and support during care and for bed mobility.</p> <p>During an observation on 08/08/18 at 4:01 PM, Resident #60 was able to pivot his legs over the edge of the bed and around the bed rail towards the floor without direction or cueing from the staff. Resident #60 utilized the bed rails to help pull to the edge of the bed and for moving from side to side when in the bed.</p> <p>During an interview on 08/08/18 at 4:31, the MDS Coordinator revealed Resident #60's quarterly MDS dated 07/12/18, section P 0100 was completed by the MDS Coordinator who filled in while she recovered from an injury. She explained the bed rail assessment dated 06/02/18</p>	F 641	<p>To monitor and maintain ongoing compliance the DON will audit Section M on admission MDS 1x week x 4 weeks, then monthly x 1 to ensure that there are no issues related to coding Section M on admission MDS assessments. Any negative findings will be addressed immediately to the administrator and corrected by MDS nurse.</p> <p>To monitor and maintain ongoing compliance the DON will audit Section P on MDS 1x week x 4 weeks, then monthly x 1 to ensure that there are no issues related to coding Section P on MDS assessments. Any negative findings will be addressed immediately to the administrator and corrected by MDS nurse.</p> <p>The results of these audits will be forwarded to the facility Quality Assurance Performance Improvement meeting for further review and recommendations.</p> <p>The title of the person responsible for implementing the acceptable plan of correction is the Administrator and/or the Director of Nursing.</p> <p>Date of Alleged Compliance is: 09/07/18</p>		

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F 641	<p>Continued From page 20</p> <p>identified the bed rails were used as an enabler for positioning and to assist with movement from side to side and care planned as an enabler not a restraint. The MDS Coordinator revealed the bed rails were incorrectly coded, and she would modify the MDS to reflect no physical restraints were used for Resident #60.</p> <p>During an interview on 08/09/18 at 4:31 PM, the Director of Nursing (DON) revealed it was her expectation the MDS was coded to reflect Resident #60 used the bed rails for bed mobility and transfers. The DON revealed the facility doesn't use restraints.</p> <p>3. Resident #36 was admitted to the facility on 10/08/10 with diagnoses which included hemiplegia (paralysis of one side of the body) affecting the left dominate side, cerebrovascular accident, and contracture of the left elbow.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 06/29/18 assessed Resident #36 to be cognitively impaired. The assessment included the resident's functional status abilities and identified extensive assistance was needed with bed mobility and total assistance was needed for transfers. Section P0100 of the MDS assessed bed rails were used daily as a physical restraint.</p> <p>During an observation on 08/08/18 at 4:12 PM, when asked Resident #36 was not able to pivot his legs over the edge of the bed and around the bed rail and made no attempt to position to the edge of the bed. Resident #36 was able to use the bed rail to pull from side to side and demonstrated for the surveyor without cues, or help from staff.</p>	F 641			

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F 641	<p>Continued From page 21</p> <p>During an interview on 08/08/18 at 4:12 PM, Nurse #6 explained Resident #36 couldn't get out of bed without staff assistance. She explained the bed rails could be used to move from side to side when in bed without staff assistance and for the resident to grasp when rolled over on to their side during care with staff assistance.</p> <p>During an interview on 08/08/18 at 4:31 PM, the MDS Coordinator explained Resident #36's quarterly MDS dated 6/29/18, section P 0100 was completed by the MDS Coordinator who filled in while she recovered from an injury. The bed rail assessment date 6/10/18 identified the bed rails were an enabler for positioning and used to assist from side to side and was care planned as an enabler. The MDS Coordinator revealed the bed rails were incorrectly coded, and she would modify the MDS to reflect no physical restraints were used for Resident #36.</p> <p>During an interview on 08/09/18 at 4:31 PM, the Director of Nursing (DON) revealed it was her expectation the MDS was coded to reflect Resident #60 used the bed rails for bed mobility. The DON confirmed the facility doesn't use restraints.</p> <p>4. Resident #29 was admitted to the facility 05/22/18 with diagnoses which included dementia.</p> <p>Review of the admission Minimum Data Set (MDS), Section M-Skin Conditions, dated 05/29/18 (with a modification MDS dated 06/04/18) assessed Resident #29 with no wounds.</p> <p>A nursing progress note dated 05/22/18 noted Resident #29 had an unstageable pressure sore</p>	F 641			

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F 641	<p>Continued From page 22 on his left heel.</p> <p>Review of physician orders noted an order written by the Family Nurse Practitioner dated 05/28/18 to "refer to wound specialist for unstageable left heel." The Family Nurse Practitioner progress note associated with the 05/28/18 order noted a diagnosis of unstageable pressure ulcer of left heel.</p> <p>A Weekly Wound Assessment dated 05/29/18 assessed Resident #29 with an unstageable pressure ulcer on his left heel which measured 4.8 centimeters X 4.7 centimeters and was present on admission to the facility 05/22/18.</p> <p>On 08/08/18 at 2:08 PM the MDS nurse stated the weekly wound report from 05/28/18 should have been referenced when the 05/29/18 admission MDS was completed for Resident #29. The MDS nurse provided the 05/29/18 weekly wound report which indicated Resident #29 had an unstageable sore on his left heel which was present on admission to the facility. The MDS nurse stated both the 05/29/18 admission MDS and 06/04/18 modification admission MDS missed the assessment of the wound. The MDS nurse stated the 05/29/18 and 06/04/18 MDS for Resident #29 should have indicated an unstageable wound at the time of the assessments.</p> <p>On 08/08/18 at 3:43 PM the Director of Nursing stated she expected the MDS to be an accurate reflection of a resident's physical status and noted the admission MDS for Resident #29 should have included the unstageable wound on Resident #29's left heel.</p>	F 641			

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F 641	<p>Continued From page 23</p> <p>On 08/10/18 the Administrator stated he expected the MDS to be an accurate reflection of a resident at the time of the assessment.</p> <p>5. Resident #65 admitted to the facility on 06/22/18 with diagnoses that included fracture of vertebra, abnormal gait, history of falls, Alzheimer's disease, and muscle weakness.</p> <p>Review of the admission Minimum Data Set (MDS) dated 06/29/18 for Resident #65 indicated under Section P0100 that bed rails were used daily as a physical restraint.</p> <p>Review of the Care Area Assessment (CAA) associated with the admission MDS dated 06/29/18 revealed Resident #65 used quarter bed rails as an enabler for bed mobility.</p> <p>During an interview on 08/09/18 at 3:50 PM the MDS Coordinator revealed Section P0100 for Resident #65's admission MDS dated 06/29/18 was completed by a MDS Coordinator who was filling in at the time. The MDS Coordinator confirmed Resident #65 used side rails as an enabler for bed mobility and not as a restraint. She acknowledged the MDS dated 06/29/18 was inaccurately coded for the use of bed rails and stated she would submit a modification to reflect no physical restraints were used for Resident #65.</p> <p>During an interview on 08/09/18 at 4:12 PM the Director of Nursing stated it was her expectation</p>	F 641			

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F 641	Continued From page 24	F 641			
F 658 SS=D	<p>for MDS assessments to be accurately coded.</p> <p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and staff interviews the facility failed to provide medication for bowel management as ordered by the physician for 1 of 6 residents with medications reviewed. (Resident #29)</p> <p>The findings included:</p> <p>Resident #29 was admitted to the facility 05/22/18 with diagnoses which included psychosis, dysphagia, malaise and dementia.</p> <p>Review of the admission Minimum Data Set for Resident #29 noted severe cognitive impairment.</p> <p>A Family Nurse Practitioner (FNP) progress note dated 07/23/18 for Resident #29 noted Resident #29 was dependent on staff for bathing, dressing, grooming, transferring, feeding and was incontinent of stool. The FNP progress note indicated Resident #29 was not ordered a laxative on admission to the facility and required a suppository on 07/23/18 due to constipation. The FNP wrote a plan for Resident #29 which included an order for Senna (a laxative), 2 tabs at bedtime. A FNP progress note dated 07/24/18 referenced Senna had been ordered for Resident</p>	F 658	<p>F658</p> <p>Services Provided Meet Professional Standards The Plan of Correcting the specific deficiency. The facility failed to provide medication for bowel management as ordered by the physician.</p> <p>The area of concern identified was that Senna was ordered on 7/23/18 and not entered into the electronic medical record by nursing and a check of handwritten orders was not completed by nursing.</p> <p>The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.</p> <ol style="list-style-type: none"> <li>1. All residents have the potential to be affected.</li> <li>2. The facility reviewed all resident ADL documentation to ensure proper bowel elimination.</li> <li>3. The facility reviewed all admissions</li> </ol>	9/7/18	

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F 658	<p>Continued From page 25 #29 effective 07/23/18.</p> <p>Review of the July 2018 physician orders and July 2018 Medication Administration Record (MAR) for Resident #29 noted the Senna had not been administered to Resident #29.</p> <p>Review of the August 2018 physician orders and August 2018 MAR for Resident #29 noted the order for Senna was included in the electronic medical record of Resident #29 effective 08/07/18 and was entered by Nurse #1. On 08/07/18 at 5:15 PM Nurse #1 stated all handwritten orders were triple checked by nurses. Nurse #1 stated she checked some of the handwritten July orders that afternoon and noted the Senna ordered 07/23/18 for Resident #29 had not been entered into the electronic medical record of Resident #29. In a follow-up interview on 08/08/18 at 11:00 AM Nurse #1 showed the handwritten nurse practitioner order dated 07/23/18 for Resident #29 and noted an area on the order for 3 separate nurse signatures. Nurse #1 explained the first signature would be from the nurse that received the order and entered it into the electronic medical record. Nurse #1 identified the first signature as Nurse #2. Nurse #1 stated ideally the second and third checks would be completed within 24 hours of the order written. The signature of Nurse #1 was noted on the second check of the 07/23/18 order for Resident #29. Nurse #1 stated she asked Nurse #2 about the order on 08/07/18 and Nurse #2 could not explain why she did not enter the 07/23/18 order for Senna in the electronic medical record of Resident #29. Nurse #1 stated both she and Nurse #2 looked at the bowel records of Resident #29 and noted he had not had any issues. Nurse #1 stated she entered the order into the electronic</p>	F 658	<p>since date of exit to verify if physician wants a laxative ordered.</p> <p>4. The facility reviewed all new orders since date of exit to ensure orders have been processed and entered into the electronic medical record.</p> <p>5. To prevent this from recurring the DON / designee will educate nursing staff on proper processing of physician/NP orders and entering them into the electronic medical record.</p> <p>The education will also include checking of handwritten orders within 24 hours of when the order was written. Newly hired nursing staff will be educated to said process during orientation.</p> <p>The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance the DON / designee will audit all new admissions weekly x4 weeks, then monthly x2 to ensure resident has laxative ordered.</p> <p>Any negative findings will be addressed immediately. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>DON / designee will audit new orders 3x weekly x4 weeks, then monthly x2 to ensure new orders to ensure proper</p>		

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F 658	Continued From page 26 medical record of Resident #29 and did not report the delay in administration of Senna ordered 07/23/18 for Resident #29 to the Director of Nursing or Family Nurse Practitioner.  On 08/08/18 at 3:43 PM the Director of Nursing (DON) explained the facility system for processing physician/nurse practitioner orders included a triple check of all handwritten orders. The DON stated the nurse that received the order was responsible for entering the order into the electronic medical record. The DON stated the second and third checks of an order should be done within 24 hours of when the order was written. The DON stated on 08/07/18 she noticed the box housing the handwritten orders was "full" and she asked the nurses working 08/07/18 to try and check some of the orders. The DON stated she was not informed about the medication variance of Senna for Resident #29 and should have been notified so a medication variance could be completed.  On 08/09/18 at 12:56 PM the Family Nurse Practitioner that wrote the order for Senna on 07/23/18 for Resident #29 stated she expected the Senna to be given at the time it was ordered.	F 658	processing of order entered into the electronic medical record.  Any negative findings will be addressed immediately by the Administrator or Director of Nursing. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.  DON/ designee will audit 3 residents, 3x week x4 weeks, then monthly x2 to ensure proper bowel elimination. Any negative findings will be addressed immediately by the Administrator or Director of Nursing. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.  The title of the person responsible for implanting the acceptable plan of correction is the Administrator and/or the Director of Nursing.  Date of Alleged Compliance is: 09/07/18		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews the facility failed to ensure 1	F 677	F677	9/7/18	

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F 677	<p>Continued From page 27</p> <p>of 1 sampled dependent resident with weight loss and wounds was assisted with provision of food at a breakfast meal. (Resident #29)</p> <p>The findings included:</p> <p>Resident #29 was admitted to the facility 05/22/18 with diagnoses which included psychosis, acute kidney failure, feeding difficulties, dysphagia, malaise and dementia.</p> <p>Review of the admission Minimum Data Set (MDS) for Resident #29 dated 05/29/18 noted severe cognitive impairment and required extensive assistance of one person with feeding.</p> <p>The Nutrition Care Area Assessment associated with the admission MDS for Resident #29 noted care plan considerations included "resident to maintain stable weights."</p> <p>The care plan for Resident #29 included a problem area initiated 06/04/18 which read, Resident has increased nutrition/hydration risk related to: diagnosis, complications related to diagnosis, placement in a skilled nursing facility, age. The goal associated with this problem area included, "Resident to maintain stable weights." One of the approaches to this problem area was, provide assistance with meals as needed to encourage intake.</p> <p>The care plan for Resident #29 included a problem area initiated 05/22/18 which read, Resident is at risk for self care deficit due to delirium, muscle weakness and decreased mobility. One of the approaches to this problem area was eating assist of one person.</p> <p>Review of physician orders noted Resident #29's</p>	F 677	<p>ADL Care Provide for Dependent Residents</p> <p>The Plan of Correcting the specific deficiency.</p> <p>The facility failed to ensure that a dependent resident was assisted with provision of food at a breakfast meal. The area of concern was identified that Resident #29 was asleep and in bed during the breakfast meal service. The Nurse Aide caring for Resident #29 was assisting other residents and did not realize that the meal tray had not been delivered.</p> <p>Nurse Aide #1 did deliver the meal tray to Resident #29 for the breakfast meal service on 8/7/18. There were no other issues identified during survey related to meal service delivery.</p> <p>The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.</p> <p>To identify other residents that have the potential to be affected the facility identified those residents requiring assistance with eating to ensure staff is aware.</p> <p>The DON/ designee educated staff on proper and timely meal service delivery and those residents requiring assistance are provided assistance with provision of food during meal service.</p> <p>Newly hired staff will be educated on said process during orientation.</p>		

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F 677	<p>Continued From page 28</p> <p>diet order was regular diet with ground meat.</p> <p>Review of weights for Resident #29 noted the following: 05/26/18 201 06/27/18 202 07/11/18 201 08/03/18 177 08/08/18 177</p> <p>On 08/07/18 at 9:13 AM observations were made of the breakfast meal service on the hall Resident #29 resided. Nurse Aide #1 and Nurse Aide #2 were observed in the assisted dining room (located on this hallway) feeding residents. The untouched breakfast tray for Resident #29 was located on the bottom shelf of an open rolling cart which was located outside this dining room. Resident #29 was observed in bed, laying on his back, and appeared to be sleeping. Nurse #2 (that was assigned to work with Resident #29 at the time of the observation) was asked if Resident #29 had been assisted with the breakfast meal and Nurse #2 reported she just arrived on the hall and wasn't aware if Resident #29 had been fed. At 9:15 AM Nurse Aide #1 was observed to place trays from residents that had finished eating on the open rolling cart (which had the untouched breakfast tray for Resident #29 still stored on it) and proceeded to push the cart (which was now completely filled with trays) towards the kitchen (in the opposite direction from the room where Resident #29 resided.) On 08/07/18 at 9:19 AM Nurse Aide #1 was asked if Resident #29 had been provided his breakfast tray. Nurse Aide #1 stated she didn't know and that she was not assigned to Resident #29. When Nurse Aide #1 looked at the untouched tray for Resident #29 she removed it from the cart and</p>	F 677	<p>The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance the DON / designee will audit all meal delivery service 3 times weekly x4 weeks, then monthly x2 to ensure residents that require assistance (dependent) are assisted with provision of food during meal service.</p> <p>Any negative findings will be addressed immediately. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>The title of the person responsible for implementing the acceptable plan of correction is the Administrator and/or the Director of Nursing.</p> <p>Date of Alleged Compliance is: 09/07/18</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345351</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/10/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>AUTUMN CARE OF SALUDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>501 ESSEOLA CIRCLE</b> <b>SALUDA, NC 28773</b>		
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F 677	Continued From page 29 proceeded to deliver the tray to the room of Resident #29. On 08/07/18 at 9:27 AM Nurse Aide #2 stated she was responsible for Resident #29 and had not taken the breakfast meal to him because she was busy feeding residents in the assisted dining room. Nurse Aide #2 stated she was not aware Resident #29 had not been offered the breakfast tray prior to surveyor intervention at 9:19 AM.  On 08/08/18 at 3:43 PM the Director of Nursing stated she expected all residents, especially those dependent on staff, to be served and assisted with their meal trays.  On 08/10/18 at 3:30 PM the Administrator stated he expected all residents, especially those dependent on staff, to be served and assisted with their meal trays.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that 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 medical record review and staff interviews the facility failed to obtain weekly weights as ordered for 1 of 2 sampled residents reviewed for nutrition and significant weight loss. (Resident #29)	F 684	F684 Quality of Care  The Plan of Correcting the specific deficiency.	9/7/18	

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F 684	<p>Continued From page 30</p> <p>The findings included:</p> <p>Resident #29 was admitted to the facility 05/22/18 with diagnoses which included psychosis, acute kidney failure, feeding difficulties, dysphagia, malaise and dementia.</p> <p>Review of the admission Minimum Data Set (MDS) for Resident #29 dated 05/29/18 noted severe cognitive impairment and required extensive assistance of one person with feeding.</p> <p>The Nutrition Care Area Assessment associated with the admission MDS for Resident #29 noted care plan considerations included "resident to maintain stable weights."</p> <p>The care plan for Resident #29 included a problem area initiated 06/04/18 which read, Resident has increased nutrition/hydration risk related to: diagnosis, complications related to diagnosis, placement in a skilled nursing facility, age. The goal associated with this problem area included, "Resident to maintain stable weights." One of the approaches to this problem area was, monitor weight per protocol.</p> <p>Review of physician orders in the medical record of Resident #29 noted an order dated 05/31/18 for weekly weights. Review of the July 2018 Medication Administration Record (MAR) for Resident #29 noted the need for a weekly weight was included on the MAR and scheduled due every Wednesday.</p> <p>Review of the medical record of Resident #29 noted weights for the following dates: 05/26/18 201 pounds (lbs)</p>	F 684	<p>The facility failed to obtain weekly weights as ordered for Resident #29. The area of concern identified that the facility lacked consistent staff to obtain weekly weights and there was lack of communication between nursing and the nursing assistants regarding process of obtaining weekly weights. Resident #29 was weighed on 8/18/18 and remained at 177 lbs.</p> <p>The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.</p> <p>To identify other residents that have the potential to be affected the facility identified those residents with orders for weekly weights to ensure they have been obtained as ordered.</p> <p>The DON/ designee educated nursing staff on the weighing process and obtaining weekly weights as ordered. Newly hired staff will be educated on said process during orientation.</p> <p>The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance the DON / designee will audit those residents with weekly weights weekly x4 weeks, then monthly x2 to ensure weights have been obtained per order.</p>		

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F 684	<p>Continued From page 31</p> <p>05/29/18 202 lbs 05/31/18 201 lbs 06/06/18 202 lbs 06/12/18 202 lbs 06/27/18 202 lbs 07/04/18 201 lbs 07/11/18 201 lbs 08/01/18 158 lbs (this weight was crossed through) 08/03/18 177 lbs</p> <p>There were no weights recorded for Resident #29 on Wednesday, July 18th or July 25th.</p> <p>On 08/08/18 at 12:08 PM the Physician of Resident #29 stated he expected staff to weigh residents as ordered and was dependent on staff to review weights and report any concerns to him or the Family Nurse Practitioner.</p> <p>On 08/08/18 at 3:43 PM the Director of Nursing (DON) stated she started working at the facility about a month prior. The DON stated around the end of July weekly interdisciplinary team meetings (IDT) were started to discuss residents at risk with reviews centered around wounds, weights, falls and behaviors. The DON recalled at the last meeting the 08/01/18 weight of Resident #29 was questioned because of the significant variance from the prior weight and the team decided to obtain a re-weight. The DON stated she just hired a nursing assistant to do weekly weights and that Nurse #3 had been overseeing weekly/monthly weights to ensure they were done as ordered. The DON explained the need for weekly weights populated on the MAR of the individual resident and the nurse on duty was responsible for making sure the weight was obtained. The DON stated she expected</p>	F 684	<p>Any negative findings will be addressed immediately. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p> <p>The title of the person responsible for implementing the acceptable plan of correction is the Administrator and/or the Director of Nursing.</p> <p>Date of Alleged Compliance is: 09/07/18</p>		

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F 684	Continued From page 32 weekly weights to be done as ordered.  On 08/08/18 at 4:55 PM the consultant Registered Dietitian stated she expected weights to be done as ordered and was dependent on them when doing reviews to address residents with weight changes.  On 08/09/18 at 12:56 PM the Family Nurse Practitioner for Resident #29 stated she expected weekly weights to be done as ordered.  On 08/09/18 at 1:34 PM Nurse #3 stated there had been a staff person assigned to do weekly weights but they left employment in June 2018 and, until the position could be filled, nurses were responsible to obtain weights. Nurse #3 stated the need for a weekly weight populated on a resident's MAR and the nurse would either verbally report the need to a nursing assistant or write the need on the assignment sheet. Nurse #3 stated she was not aware the weekly weight for Resident #29 was not obtained on 07/18/18 or 07/25/18. Nurse #3 stated because of the significant weight change Resident #29 was weighed again on 08/18/18 and the resident's weight remained at 177 lbs.  On 08/10/18 at 3:30 PM the Administrator stated he expected weekly weights to be done as ordered.	F 684			
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	F 880		9/7/18	

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F 880	<p>Continued From page 33</p> <p>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the</p>	F 880			

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F 880	<p>Continued From page 34 circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to implement infection control transmission-based precautions by not placing signage on the door frame, and not placing Personal Protective Equipment outside the entrance door for a known infectious agent identified for 1 of 1 resident reviewed for a urinary tract infection (Resident #2).</p> <p>Findings included:</p> <p>A review of the facility policy titled, "Infection Control-Transmission Based Precautions," revision date 04/16 read in part; Contact precautions were intended to prevent transmission of infectious agents that could</p>	F 880	<p>F880</p> <p>The Plan of Correcting the specific deficiency.</p> <p>The facility failed to implement infection control transmission-based precautions by not placing signage on the door frame, and not placing Personal Protective Equipment outside the entrance door for a known infectious agent.</p> <p>The area of concern identified that the facility was aware of a urine culture dated 8/6/18 that was positive for ESBL and at this time did not post the required signage</p>		

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F 880	<p>Continued From page 35</p> <p>spread by direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of urine or fecal incontinence suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment (PPE) was recommended. A sign would be placed on the door frame of the resident's room indicating that visitors should stop at the Nurses station before entering. Staff should educate visitors regarding donning appropriate PPE. Transmission-Based precautions will remain in effect for a limited time period while the risk of transmission of the infectious agent persists or for the duration of the illness.</p> <p>Review of a urine culture dated 08/06/18 identified Resident #2 was positive for the organism, Extended Spectrum B-Lactamase (ESBL) (an antibiotic resisting bacteria know to spread to others through contact transmission).</p> <p>A review of a physician's order written for Resident #2 on 08/06/18 revealed Amoxicillin Clavulanate (an antibiotic medication used as a treatment for ESBL) was started and to be continue for 10 days.</p> <p>An observation on 08/07/18 at 12:30 PM and 2:30 PM revealed no PPE outside the door, or signage posted on the door frame indicating contact precautions were being used for Resident #2.</p> <p>An observation on 08/08/18 at 9:20 AM and 12:25 PM revealed no PPE outside the door, or signage posted on the door frame indicating contact precautions were being used for Resident #2.</p> <p>During an interview on 08/09/18 at 9:37 AM,</p>	F 880	<p>or place the PPE equipment outside the door. On 8/9/18 the contact precautions sign and PPE had been put into place outside the resident's door.</p> <p>The Procedure for Implementing the Acceptable Plan of correction for the specific deficiency cited.</p> <p>To identify other residents that have the potential to be affected the facility identified those residents with known infectious agents to ensure proper signage is posted and PPE is placed outside entrance door.</p> <p>The DON/ designee educated nursing staff on placing proper signage on the door frame and PPE is placed outside entrance once urine cultures /other tests come back positive with an infectious agent.</p> <p>The monitoring procedure to assure the Plan of Correction is corrected and the specific deficiency cited remains corrected and in compliance with regulatory requirements.</p> <p>To monitor and maintain ongoing compliance the DON / designee will audit those residents with known infectious agents weekly x4 weeks, then monthly x2 to ensure the proper signage is on the door frame and PPE is placed outside entrance door. Any negative findings will be addressed immediately. The results of the findings will be forwarded to the facility QAPI committee for further review and recommendations.</p>		

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F 880	<p>Continued From page 36</p> <p>Nurse #5 explained the roommate was temporarily moved to another room due to Resident #2 being placed on isolation precautions due to the diagnosis of ESBL. No PPE was outside the door, or signage posted on the door frame indicating contact precautions were being used.</p> <p>An observation on 08/09/18 at 4:25 PM revealed Resident #2 and a visitor were sitting in the resident's room. There was no PPE equipment outside the door, or signage posted on the door frame indicating contact precautions were being used for Resident #2.</p> <p>Review of Resident #2's physician order written on 08/09/18 revealed Contact Precautions were initiated every shift for ESBL.</p> <p>During an interview on 08/09/18 at 5:35 PM, the Nurse #3 confirmed Resident #2 was identified to have an infectious agent on 08/06/18. The resident's roommate was moved to a different room per facility policy. She thought some of the staff were aware of the diagnoses and they should use contact precautions. It was discussed to place PPE and a contact precaution sign but wasn't done until 08/09/18. She confirmed there had not been PPE placed outside the door for the staff to use when providing incontinence care for Resident #2 until 08/09/18. She explained the facility's infection control policy was to place a precaution sign on the door frame to inform staff and visitors what steps to take before entering the resident's room and to identify which precaution was implemented.</p> <p>During an interview on 08/09/18 at 5:43 PM, the Director of Nursing revealed it was her</p>	F 880	<p>The DON / designee will audit all urine tests (lab/diagnostics) weekly x4, then monthly x2 to ensure the proper signage is on the door frame and PPE is placed outside entrance door if results show infectious agent.</p> <p>The title of the person responsible for implementing the acceptable plan of correction is the Administrator.</p> <p>Date of Alleged Compliance is: 09/07/18</p>		

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F 880	Continued From page 37 expectation contact precautions would have been in place for Resident #2 on 08/06/18 when ESBL was identified. She expected PPE would be placed outside the door and contact precaution signage posted on the door frame visible to staff and visitors to read before entering the room. She confirmed a contact precautions sign and PPE had been placed on 08/09/18.	F 880		