

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

PRINTED: 09/14/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2018
NAME OF PROVIDER OR SUPPLIER PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		
(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 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 8/06/18 through 8/10/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 7/22/18 and was removed on 8/9/18. An extended survey was also conducted. No deficiencies were cited as a result of the complaint investigation.	F 000			
F 636 SS=E	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.	F 636		9/5/18	

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

TITLE

(X6) DATE

Electronically Signed

08/24/2018

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 636	<p>Continued From page 1</p> <p>(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. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (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. (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>	F 636			

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F 636	<p>Continued From page 2</p> <p>(iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to conduct an annual comprehensive assessment for 6 of 29 residents reviewed for Resident Comprehensive Assessments (Residents #18, #3, #35, #20, #37, and # 24).</p> <p>Findings included:</p> <p>1. Resident # 18 was admitted to the facility 6/17/13. Active diagnoses included atrial fibrillation, malignant neoplasm (tumor) of the prostate and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessments completed for Resident #18 revealed the last assessment completed was a quarterly assessment completed on 3/27/18.</p> <p>On 8/8/18 Resident #18's annual comprehensive assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 6/20/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section B-Hearing, Speech and Vision, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnosis, Section J-Health Conditions, Section L-Oral/Dental Status, Section M-Skin Conditions, Section N-Medications, and Section P- Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #18's annual MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be</p>	F 636	<p>Submission of the response to The Statement of Deficiencies by The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required.</p> <p>F 636 – Comprehensive Assessments & Timing</p> <p>Criteria #1: It was identified that the facility failed to do 6 of 29 resident Comprehensive Assessments timely. All affected resident's MDS Assessment were completed by 8/21/2018.</p> <p>Criteria # 2: A 100% audit was completed on 8/21/2018 to ensure all late assessments were identified. All assessments will be up to date by 09/05/18.</p> <p>Criteria #3 : The MDS team was educated on timeliness of assessments on 8/14/2018.</p> <p>Criteria #4: The Administrator will review the MDS calendar due dates with the MDS team daily, Monday through Friday with the weekends being reviewed on Friday. The Administrator will monitor</p>		

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F 636	<p>Continued From page 3</p> <p>absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>2. Resident # 3 was admitted to the facility 11/25/13. Active diagnoses included pneumonia, heart failure, chronic kidney disease and diabetes mellitus. A review of the Minimum Data Set (MDS) assessments completed for Resident #3 revealed the last assessment completed was a quarterly assessment completed on 3/12/18.</p> <p>On 8/8/18 Resident # 3's annual comprehensive assessment with an Assessment Reference Date of 6/11/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section I-Active Diagnosis, Section J-Health Conditions, and Section L-Oral/Dental Status.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #3's annual MDS which should have been completed in June 2018. The MDS Nurse stated had a family emergency</p>	F 636	<p>for timely completion daily x 1 month, weekly x 2 months, and monthly x 3 months. In the Administrator's absence, the DON or ADON will assume the responsibility of the POC. The Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the regulatory requirements.</p> <p>09/05/18</p>		

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F 636	<p>Continued From page 4</p> <p>in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>3. Resident #35 was admitted to the facility on 4/10/14. Active diagnoses included dementia, Alzheimer's disease, diabetes mellitus, and psychosis. A review of the Minimum Data Set (MDS) assessments completed for Resident #35 revealed the last assessment completed was a quarterly assessment dated 4/2/18.</p> <p>On 8/8/18 Resident #35's annual comprehensive assessment with an Assessment Reference Date of 7/2/18 was observed in the electronic medical record as "open". The incomplete sections were Section B-Hearing, Speech and Vision, Section C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section M-Skin Conditions, Section N-Medications, Section P-Restraints and Alarms, and Section Q-Participation in</p>	F 636			

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F 636	<p>Continued From page 5 Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #35's annual MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>4. Resident #20 was admitted to the facility on 5/9/16. Active diagnoses included sepsis, systemic inflammatory response and dementia. A review of the Minimum Data Set (MDS) assessments completed for Resident #20 revealed the last assessment completed was a quarterly assessment dated 4/2/18.</p> <p>On 8/8/18 Resident #20's annual comprehensive assessment with an Assessment Reference Date of 7/2/18 was observed in the electronic medical record as "open". The incomplete sections were Section B-Hearing, Speech and Vision, Section</p>	F 636			

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F 636	<p>Continued From page 6</p> <p>C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section F-Preferences for Customary Routine and Activities, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section M-Skin Conditions, Section N-Medications, Section O-Special Treatments, Procedures and Programs, Section P-Restraints and Alarms and Section Q-Participation in Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #20's annual MDS which should have been completed in July 2018. The MDS Nurse stated that she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>5. Resident #37 was admitted to the facility on 8/31/17. Active diagnoses included cerebral infarction (stroke), contracture of the right</p>	F 636			

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F 636	<p>Continued From page 7</p> <p>shoulder and flaccid hemiplegia (paralysis) affecting the right dominant side. A review of the Minimum Data Set (MDS) assessments completed for Resident #37 revealed the last assessment completed was a quarterly assessment dated 4/4/18.</p> <p>On 8/8/18 Resident #37's annual comprehensive assessment with an Assessment Reference Date of 7/3/18 was observed in the electronic medical record as "open". The incomplete sections were Section C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, Section P-Restraints and Alarms and Section Q-Participation in Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #37's annual MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation assessments be completed on time.</p> <p>An interview was conducted with the</p>	F 636			

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F 636	<p>Continued From page 8</p> <p>Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>6. Resident #24 was admitted 6/3/17. Active diagnoses included psychosis, cerebral infarction and dementia. A review of the Minimum Data Set (MDS) assessments completed for Resident #24 revealed the last assessment completed was a quarterly assessment dated 4/5/18.</p> <p>On 8/18/18 Resident #24's annual comprehensive assessment with an Assessment Reference Date of 7/5/18 was observed in the electronic medical record as "open". The incomplete sections were Section B-Hearing, Speech and Vision, Section C-Cognitive Patterns, Section D-Mood, Section E-Preferences for Customary Routines and Activities, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section M-Skin Conditions, Section N-Medications, Section O-Special Treatments, Procedures and Programs, Section P-Restraints and Alarms and Section Q-Participation in Assessments and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #24's annual MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete assessments during her leave. She reported the facility recently hired additional staff</p>	F 636			

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F 636	Continued From page 9 to complete assessments. An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time. An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.	F 636			
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment for 13 of 29 residents reviewed for Resident Assessments (Residents #13, #11, #17, #19, #14, #39, #34, #36, #8, #38, #16, #20, and # 4). Findings included: 1. Resident # 13 was admitted to the facility 2/2/17. Active diagnoses included diabetes mellitus, major depressive disorder, and sepsis. A review of the (Minimum Data Set) MDS assessments completed for Resident #13 revealed the last assessment completed was a quarterly assessment completed on 3/22/18.	F 638	F 638 – Quarterly Assessment at least every 3 months Criteria # 1: It was identified that the facility failed to complete quarterly MDS assessments timely. All affected resident's MDS Assessments were complete by 8/21/2018. Criteria # 2: A 100% audit was completed on 8/21/2018 to ensure all late assessments were identified. all assessments will be completed and up to	9/5/18	

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F 638	<p>Continued From page 10</p> <p>On 8/8/18 Resident #13's quarterly assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 6/13/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section I-Active Diagnoses, Section J-Health Conditions and Section N-Medications.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #13's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete the MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>2. Resident # 11 was admitted to the facility 3/9/18. Active diagnoses included contracted left knee, dysphagia (difficulty swallowing) and diabetes mellitus. A review of the Minimum Data Set (MDS) assessments completed for Resident</p>	F 638	<p>date by 9/5/2018.</p> <p>Criteria # 3: The MDS team was educated on the timeliness of assessments on 08/14/18.</p> <p>Criteria # 4 : The Administrator will review the MDS calendar due dates with the MDS team daily, Monday through Friday with the weekends being reviewed on Friday. The Administrator will monitor for timely completion daily x 1 month, weekly x 2 months, and monthly x 3 months. In the Administrator's absence, the DON or ADON will assume the responsibility of the POC. The Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the regulatory requirements. 09/05/18</p>		

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F 638	<p>Continued From page 11</p> <p>#11 revealed the last assessment completed was an admission assessment completed on 3/16/18.</p> <p>On 8/8/18 Resident #11's quarterly assessment with an Assessment Reference Date of 6/14/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #11's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported that facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>3. Resident #17 was admitted to the facility 11/6/17. Active diagnoses included: chronic obstructive pulmonary disease, diabetes mellitus,</p>	F 638			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 638	<p>Continued From page 12</p> <p>left side hemiplegia (paralysis), and gastrostomy (artificial opening in the stomach). A review of the Minimum Data Set (MDS) assessments completed for Resident #17 revealed the last assessment completed was an annual assessment on 3/27/18.</p> <p>On 8/8/18 Resident #17's quarterly assessment with an Assessment Reference Date of 6/15/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section B-Hearing, Vision and Speech, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #17's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it</p>	F 638			

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F 638	<p>Continued From page 13</p> <p>is his expectation assessments would be completed as required.</p> <p>4. Resident #19 was admitted 4/17/17. Active diagnoses included: gastrointestinal hemorrhage, chronic kidney disease, and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessments completed for Resident #19 revealed the last assessment completed was an annual assessment on 3/29/18.</p> <p>On 8/8/18 Resident #19's quarterly assessment with an Assessment Reference Date of 6/18/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #19's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p>	F 638			

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F 638	<p>Continued From page 14</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>5. Resident #14 was admitted to the facility 10/23/15. Active diagnoses included: acute kidney failure, diabetes mellitus, chronic leukemia, bilateral below the knee amputation, and peripheral vascular disease. A review of the Minimum Data Set (MDS) assessments completed for Resident #14 revealed the last assessment completed was a re-entry assessment dated 4/23/18.</p> <p>On 8/8/18 Resident #14's quarterly assessment with an Assessment Reference Date of 6/19/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #14's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of</p>	F 638			

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F 638	<p>Continued From page 15</p> <p>Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>6. Resident #39 was admitted to the facility 7/31/15. Active diagnoses included: diabetes mellitus, dementia, and atrial fibrillation. A review of the Minimum Data Set (MDS) assessments completed for Resident #39 revealed the last assessment completed was a quarterly assessment dated 4/4/18.</p> <p>On 8/8/18 Resident #39's quarterly assessment with an Assessment Reference Date of 6/21/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #39's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional</p>	F 638			

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F 638	<p>Continued From page 16 staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>7. Resident #34 was admitted to the facility on 9/20/17. Active diagnoses included acute kidney failure with tubular necrosis. A review of the Minimum Data Set (MDS) assessments completed for Resident #34 revealed the last assessment completed was a quarterly assessment dated 4/2/18.</p> <p>On 8/8/18 Resident #34's quarterly assessment with an Assessment Reference Date of 6/22/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #34's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The</p>	F 638			

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F 638	<p>Continued From page 17</p> <p>MDS Nurse indicated there was no one to complete MDS assessments during her leave She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>8. Resident #36 was admitted 4/21/00. Active diagnoses included: neurotraumatic intracerebral hemorrhage, intracranial injury and dysphagia (difficulty swallowing). A review of the Minimum Data Set (MDS) assessments completed for Resident #35 revealed the last assessment completed was a quarterly assessment dated 4/2/18.</p> <p>On 8/8/18 Resident #36's quarterly assessment with an Assessment Reference Date of 6/22/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #36's quarterly MDS which should have been completed in June 2018.</p>	F 638			

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F 638	<p>Continued From page 18</p> <p>The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>9. Resident #8 was admitted to the facility on 8/13/14. Active diagnoses included: sepsis, urinary tract infection, prostate cancer and diabetes mellitus. A review of the Minimum Data Set (MDS) assessments completed for Resident #8 revealed the last assessment completed was an annual assessment dated 4/2/18.</p> <p>On 8/8/18 Resident #8's quarterly assessment with an Assessment Reference Date of 7/2/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section B-Hearing, Speech and Vision, Section C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, Section</p>	F 638			

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F 638	<p>Continued From page 19</p> <p>P-Restraints and Alarms and Section Q-Participation in Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #8's quarterly MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>10. Resident #38 was admitted to the facility on 3/5/12. Active diagnoses included peripheral vascular disease, dementia, and psychotic disorder. A review of the Minimum Data Set (MDS) assessments completed for Resident #38 revealed the last assessment completed was a quarterly assessment dated 4/4/18.</p> <p>On 8/8/18 Resident #38's quarterly assessment with an Assessment Reference Date of 7/3/18 was observed in the electronic medical record as "open" and not completed. The incomplete</p>	F 638			

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F 638	<p>Continued From page 20</p> <p>sections were Section C-Cognitive Patterns, Section D-Mood, and Section E-Behavior.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #38's quarterly MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>11. Resident #16 was admitted to the facility 8/4/98. Active diagnoses included cerebral infarction, dementia and major depressive disorder. A review of the Minimum Data Set (MDS) assessments completed for Resident #16 revealed the last assessment completed was a quarterly dated 3/23/18.</p> <p>On 8/8/18 Resident # 16's quarterly assessment with an Assessment Reference Date of 6/12/18 was observed in the electronic medical record as "open" and not completed. The incomplete</p>	F 638			

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F 638	<p>Continued From page 21</p> <p>sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #16's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>12. Resident #20 was admitted to the facility 6/24/14. Active diagnoses included Alzheimer's disease, diabetes mellitus, psychosis and sleep disorder. A review of the Minimum Data Set (MDS) assessments completed for Resident #20 revealed the last assessment completed was an annual assessment dated 4/10/18.</p> <p>On 8/8/18 Resident #20's quarterly assessment</p>	F 638			

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F 638	<p>Continued From page 22</p> <p>with an Assessment Reference Date of 7/6/18 was observed in the medical record as "open" and not completed. The incomplete sections were Section C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, Section P-Restraints and Alarms, and Section Q-Participation in Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #20's quarterly MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.</p> <p>13. Resident #4 was admitted to the facility 12/30/15. Active diagnoses included cholangitis (infection of the bile duct), sepsis and delusional</p>	F 638			

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F 638	<p>Continued From page 23</p> <p>disorder. A review of the Minimum Data Set (MDS) assessments completed for Resident #4 revealed the last assessment completed was an annual assessment dated 4/17/18.</p> <p>On 8/8/18 Resident #4's quarterly assessment with an Assessment Reference Date of 7/9/18 was observed in the medical record as "open" and not completed. The incomplete sections were Section C-Cognitive Patterns, Section D-Mood, Section E-Behavior, Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications, Section P-Restraints and Alarms and Section Q-Participation in Assessment and Goal Setting.</p> <p>An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #4's quarterly MDS which should have been completed in July 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.</p> <p>An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.</p> <p>An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it</p>	F 638			

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F 638	Continued From page 24	F 638			
F 641	is his expectation assessments would be completed as required.				
SS=D	<p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interviews, and observations, the facility failed to accurately code a Quarterly Minimum Data Set (a tool used for resident assessments) for 1 of 63 residents (Resident #68) reviewed.</p> <p>Findings included:</p> <p>Resident #68 was re-admitted to the facility on 7/19/18. A gastrostomy (feeding) tube was in place on re-admission. Review of the Quarterly Minimum Data Set (MDS) dated 7/20/18 revealed Resident #68 was severely cognitively impaired, had no behaviors or rejection of care, and Activities of Daily Living (ADLs) required extensive to total assistance to be completed. Active diagnoses included diabetes mellitus (DM), non-Alzheimer's dementia, malnutrition, and convulsions. Resident #68 received a mechanically altered, therapeutic diet and was not assessed for a feeding tube or parenteral (tube) feedings.</p> <p>Review of the physician orders dated 7/1/18 through 7/31/18 revealed an order to "Cleanse g-tube (gastrostomy tube) /c (with) NS (Normal Saline) and apply dry drsg (dressing) QOD (every other day) & (and) PRN (as needed)." An</p>	F 641	<p>8/10/18</p> <p>F641 – Accuracy of Assessments</p> <p>Criteria #1: The facility failed to code a feeding tube on a Quarterly MDS accurately for 1 of 63 residents. The affected resident's MDS was corrected on 8/10/2018.</p> <p>Criteria # 2: A 100% audit was done on all residents with Feeding tubes to ensure Section K of the MDS was coded correctly on 08/09/18.</p> <p>Criteria # 3: The Dietary Manager was educated on 8/9/2018 regarding coding accuracy.</p> <p>Criteria # 4: All closed MDS assessments will be audited for accuracy daily x 4 weeks, weekly x 2 months, and monthly x 3 months. The Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the regulatory requirements.</p>		

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F 641	Continued From page 25 additional order read, "Dietary consult: Continuous tube feeding due to low albumin. May have pleasure foods." An additional order read, "Jevity 1.5 tube feeding at 55ml (milliliter)/ (per) hour." A physician's progress note dated 7/20/18 read, in part, "physical exam-Abdomen: PEG (feeding) tube is in place." The plan read, in part, "Tube feeding will be continued." An interview was conducted with the MDS Coordinator on 8/9/18 at 3:40 PM. She stated information for MDS completion was gathered from resident interviews, observations, the electronic and paper chart, nursing notes, physician notes, physician orders, consult notes, and ADL notes. She stated Resident #68 had a feeding tube and it had been present since a re-admission in October 2017. She stated the Quarterly MDS was not coded for parenteral feeding or a feeding tube and should have been. She stated the Quarterly MDS was an inaccurate assessment. An interview was conducted on 8/9/18 at 3:55 PM with the Director of Nursing. She stated Resident #68 had a feeding tube. She stated her expectations included the MDS was accurately coded and accurately reflected the patients' clinical picture. She also stated the Quarterly MDS dated 7/20/18 should have been coded for a feeding tube, but was not.	F 641	09/05/18		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		8/10/18	

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F 689	<p>Continued From page 26</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, and observations the facility failed to provide supervision to prevent a severely cognitively impaired resident (Resident #274) who displayed wandering behaviors from exiting the facility unsupervised for 1 of 3 residents reviewed for accidents. The resident was returned to the facility only after a staff member was alerted by an alert and oriented resident that Resident #274 was observed in an adjoining parking lot. No injuries were reported.</p> <p>Immediate Jeopardy began on 7/22/18 when Resident #274 was observed outside the facility without supervision in her wheelchair in the facility parking lot. The resident was retrieved by Nurse #1 and returned to the facility with no physical injuries. Immediate jeopardy was removed on 8/8/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.</p> <p>Findings Included:</p> <p>Resident #274 was admitted to the facility on 6/29/18. Her admitting diagnoses included</p>	F 689	<p>F689 Free of Accident Hazards/ Supervision/ Devices</p> <p>Criteria #1: Resident #274 was observed outside in her wheelchair without supervision in the facility parking lot. She was brought back into the facility by a Staff Nurse. She was without injury. A Wanderguard was placed on 7/22/18. A new Elopement Risk Assessment was completed on 7/22/18 and 07/24/18 the care plan was updated on 7/22/18.</p> <p>Criteria # 2: On 7/24/18, a 100% audit was completed on all residents regarding the risk for elopement by the DON and ADON. An audit was conducted for all doors and Wanderguard bracelets and units on 7/23/18 to assess proper function by the Administrator and ADON. On 7/23/18, a staff member was assigned to monitor the door after the receptionist leaves (from 4:30 pm-8:00 pm.) Effective 08/20/18, The facility doors remained locked at all times requiring visitors to be buzzed in or out of the facility.</p>		

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F 689	<p>Continued From page 27</p> <p>schizophrenia, muscle weakness, difficulty walking, cognitive communication deficit, dementia with behavioral disturbances, and anxiety disorder.</p> <p>Review of Resident #274's minimum data set (MDS) assessment dated 7/6/18 revealed she was assessed as severely cognitively impaired. She was assessed to have behaviors not directed towards others 1 to 3 days of the previous 7 days. She required extensive assistance by one staff member for bed mobility, transfers, and locomotion off unit. She had no impairment to the range of motion of her upper and lower extremities and used a wheelchair as a mobility device. She received antipsychotic, antidepressant, and anti-anxiety medications 7 of the previous 7 days. No restraints, including wandering/elopement alarms were in use at that time.</p> <p>Review of Resident #274's care plan dated 7/12/18 revealed she was care planned for memory problems and impaired decision making as she was unable to decide what clothes to wear, when to go to meals, what time to eat, or when to go to bed and sleep for the night related to impaired decision making ability secondary to dementia with behavioral disturbances. The interventions included to monitor for any changes or decline in cognitive status. There were no care plans present for supervision to prevent wandering.</p> <p>Review of an undated and unsigned Elopement Risk Assessment, for Resident #274 revealed the form instructions read "Complete upon admission or per facility policy. For each question under Resident Evaluation Factors, check yes/no as</p>	F 689	<p>Criteria # 3: On 8/8/18 staff members (nurses, nurse aides, physical therapist, occupational therapist, speech language therapists, therapy assistants, department managers, dietary, housekeeping and laundry) were in-serviced on appropriate response to exit seeking behavior, notification of administration, and assignment of staff monitoring of door from 4:30-8:00 p.m. All nurses were in-serviced on proper completion of the Elopement Risk Assessment.</p> <p>No staff member will be permitted to return to work until they have been in-serviced. All new Nurses will be educated in orientation regarding the completeness and accuracy of the elopement assessment. The QAA Committee and Medical Director met on 7/24/18 and 8/8/18 and approved this Allegation of Compliance.</p> <p>Criteria # 4 : The DON will review all new admission's, readmission and significant change Elopement Risk Assessments for accuracy weekly x 8, monthly x 2, and quarterly x3. The ADON will assume responsibility of this POC in the DON's absence.</p> <p>The Elopement Audit Tool will be completed monthly x3 and then quarterly x 3.</p> <p>The Director of Nursing will incorporate the POC</p>		

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F 689	<p>Continued From page 28</p> <p>appropriate. Check all interventions used then summarize findings, conclusions and recommendations in the space provided." Resident #274 was assessed, and the intervention put in place was identification bracelets. The interventions to be on the care plan were left blank. There was no documentation in the summarization/conclusions/recommendations section of the assessment. The Elopement Risk Assessment did not specify if the resident was at risk for elopement or not.</p> <p>Review of Resident #274's nurse's notes revealed no nurse's notes were written with regards to an attempted unsupervised exit from the facility by Resident #274 around 2 PM on 7/22/18. This attempted exit was made known to the surveyor per interviews with Nurse #1, Nurse Aide #1, and Resident #110.</p> <p>Review of a nurse's note dated 7/22/18 at 7:11 PM, signed by the House Supervisor, revealed Resident #274 made one unassisted exit from the facility. Resident #274 was assisted back in to the facility and was documented to be unharmed. A wander guard was put in place and the family was notified. No further information was documented.</p> <p>Review of an undated and unsigned Elopement Risk Assessment revealed the form instructions read "Complete upon admission or per facility policy. For each question under Resident Evaluation Factors, check yes/no as appropriate. Check all interventions used then summarize findings, conclusions and recommendations in the space provided. "Resident #274 was assessed, and the intervention put in place was personal safety alarm devise. The interventions to</p>	F 689	<p>into the facility's monthly QAA meeting to evaluate the effectiveness and compliance of the regulatory requirements.</p>		

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F 689	<p>Continued From page 29</p> <p>be on the care plan were left blank. There was no documentation in the summarization/conclusions/recommendations section again. The Elopement Risk Assessment did not specify if the resident was at risk for elopement or not.</p> <p>Review of a facility report completed by the Director of Nursing revealed on 7/22/18 the Director of Nursing was notified by staff that Resident #274 had gone out through the front door in her wheelchair. Resident #274 was brought back into the facility by Nurse #1. Resident #274 was assessed and found to have no injuries. Resident #274 had a wander guard applied following the occurrence. The Resident Representative (RP) was called and made aware. On 7/23/18 Resident #274 was interviewed by the Director of Nursing regarding her desire to sit outside and informed Resident #274 she could continue to go outside only with staff or family at her request and the resident verbalized understanding and the wander guard was left in place. This report was signed by the Director of Nursing and not dated or timed.</p> <p>Review of a care plan intervention dated 7/22/18 revealed the resident had a wander guard in place related to risk for elopement/exit seeking behaviors.</p> <p>Review of www.wunderground.com for Tarboro weather history revealed the temperatures on 7/22/18 at 5:01 PM was 85 degrees Fahrenheit. The humidity was 69%, there was variable 6 mile per hour winds, no precipitation, and it was mostly cloudy.</p> <p>The House Supervisor no longer worked at the</p>	F 689			

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F 689	<p>Continued From page 30 facility and was unavailable for interview.</p> <p>During an interview on 8/7/18 at 3:22 PM Nurse Aide #2 stated Resident #274 would easily get lost and ask where her room or the dining room was. She further stated Resident #274 would usually be in the bathroom or go to the dining room and was very forgetful and would not remember things that were told to her during conversation. She further stated she did not consider Resident #274's behavior to be wandering because she would simply be lost, so she did not feel she needed to report the behavior. She further stated the resident had a wander guard, so she must be a wandering resident. Nurse Aide #2 was not working when the resident eloped.</p> <p>During an interview on 8/7/18 at 3:39 PM Nurse #2 stated she was the nurse supervisor for the 200 hall. She further stated she was familiar with Resident #274's care. She stated that Resident #274 was very forgetful and would not be compliant with reeducation especially when she first arrived in the facility. She further stated Resident #274 would also get lost very easily and every evening she came to the nurse's station to ask where the dining room was. She further stated Resident #274 had behaved in this manner since she arrived in June but no staff had ever reported to her that she had made statements that she was leaving the facility.</p> <p>During an interview on 8/7/18 at 4:18 PM Nurse Aide #1 stated she was familiar with Resident #274 and was assigned to care for her during the 3:00 PM to 11:00 PM Shift on 7/22/18. She stated Resident #274 had very bad memory problems and would ask the same questions over and over</p>	F 689			

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

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F 689	Continued From page 31 and would get confused a lot. She further stated she would forget things said to her five minutes later. She stated it was not very effective to reeducate Resident #274. The Nurse Aide stated Resident #274 once said she was having a baby and needed to go out of the facility to have the baby. Resident #274 had also stated to the Nurse Aide that family was coming to get her when no one was coming to get her. The Nurse Aide stated she would go to the front lobby occasionally and get confused about where she was going and state she was being picked up by family. She further stated this had been going on during her entire stay since her admission in June. Nurse Aide #1 stated this was her normal behavior and she did not report it to anyone because everyone knew she was forgetful and would say strange things. She then stated one time Resident #274 was so convincing saying her brother was coming to get her that the Nurse Aide pushed Resident #274 away from the lobby to the 200 hall nurse's station to check with the House Supervisor if Resident #274's brother really was coming to get the resident. She stated it was around 2:30 PM or 3:00 PM on the same day she exited the building unassisted but she was unsure of the exact time or date. She further stated the brother was not coming to get her and the House Supervisor explained to Resident #274 she could not leave the facility without supervision. She further stated she believed that was all that was done by the House Supervisor in response to the behaviors. The Nurse Aide then stated later that day the resident was supposed to be in the dining room eating. Nurse Aide #1 last saw the resident sometime around 4 or 4:30 PM that day at the 200 hall nurse's station as the resident was going to dinner. Nurse Aide #1 remained on the hall assisting other residents with dinner. She stated	F 689			

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F 689	<p>Continued From page 32</p> <p>Resident #274 either left the dining room or never stopped at the dining room and went out the front door. She further stated the resident left the facility and was headed towards the eye center. The Nurse Aide stated she did not know how far she made it and only found out about the incident after Resident #274 had been brought back inside the facility. Nurse Aide #1 concluded that Resident #274 was wearing clothing and appropriate footwear that evening as she was on her way to the dining room.</p> <p>During an interview on 8/7/18 at 4:34 PM Nurse #1 stated she usually worked on 100 east hall and was not assigned to Resident #274. She further stated she was not familiar with Resident #274's care. She stated a visitor came in to the facility on 7/22/18 "way before" Resident #274's unsupervised exit and was opening the door for Resident #274 not knowing the residents could not go outside unsupervised. She stated she told the visitor please do not let the residents outside before asking a nurse. She further stated had she not intervened Resident #274 was going to exit the facility but had not made it out of the door. She then stated she called the 200 hall and spoke to the House Supervisor, who was the floor supervisor for Resident #274, and the House Supervisor informed Nurse #1 that Resident #274 was not allowed to go outside without supervision. A Nurse Aide from the 200 hall then came and took the resident back to the 200 hall. The nurse stated later that day on 7/22/18 one of her alert and oriented residents (Resident #110) alerted her to the fact that the resident was outside. She was unable to recall the time this occurred, but it was well after the first incident. She stated she asked Resident #110 who the resident was and she told her that Resident #274</p>	F 689			

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F 689	<p>Continued From page 33</p> <p>was outside in the far parking lot. She further stated she looked and could see out the 100 hall exit door at the end of the hall and could see the resident. She stated there were two sections directly across from the rehab hall and she was in the parking sections furthest away from the facility. She immediately retrieved Resident #274 and assessed her to have no injuries. She reported what had just occurred to the House Supervisor and a 200 hall Nurse Aide came and got Resident #274 and took her back to the 200 hall. She was unable to recall which nurse aid it was who retrieved the resident both times.</p> <p>During an interview on 8/8/18 at 8:07 AM Resident #110 stated he was at the front lobby one Saturday or Sunday (7/21 or 7/22) at about 2 PM and saw a resident that he did not know at that time attempt to leave the facility and Nurse #1 stopped the resident who was halfway out the door and told the resident she could not go outside without supervision. He further stated Nurse #1 then brought the resident back inside. He stated his wife was visiting him around 5 PM on that same day and the blinds were open in his room. He saw the same resident pass by his window and was concerned. He was already in his wheelchair, so he went to the hall and found Nurse #1 and asked her if that same resident was supposed to be outside. Nurse #1 told him no so he informed her she was outside and then looked out the 100 hall back door and said, "in fact, there she goes." He stated at that point she was outside in the parking lot of the rehab area about in the middle to further side of the parking lot. He further stated he could not tell how far it was.</p> <p>During an interview on 8/8/18 at 8:35 AM Nurse Aide #3 stated Resident #274 had dementia and</p>	F 689			

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F 689	<p>Continued From page 34</p> <p>would not always remember reeducation. She further stated she could sometimes get lost and would talk about being a teacher and needing her classroom. She further stated she had seen Resident #274 wander daily in the facility. The nurse aide stated if wandering was identified the nurse would document it. She further stated Resident #274 had wandered during her entire stay in the facility since June and it was her baseline behavior so because staff were aware she wandered, she did not report the behavior to her nurse.</p> <p>During an interview on 8/8/18 at 9:05 AM Nurse #3 who was the 200 hall team leader stated stated if a resident was observed attempting to exit the facility who required supervision outside the facility, it was the facility's protocol to place a wander guard on the resident and assess them. She further stated that if she was told Resident #274 had attempted to leave the facility that would be abnormal behavior for her and she would have placed a wander guard on the resident and notified the Director of Nursing as soon as she was aware. She further stated no staff had shared any concerns with her about Resident #274's confusion or wandering prior to 7/22/18.</p> <p>During an interview on 8/8/18 at 9:57 AM the Director of Nursing RN stated the Elopement Risk Assessment form was having a glitch in their computer system and could not be signed and dated by some staff. She further stated it would not prevent the staff from completing the summarization/conclusions/recommendations section. She stated if she performed the evaluation she would complete the summarization/conclusions/recommendations</p>	F 689			

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F 689	<p>Continued From page 35</p> <p>sections, however, since all the questions in the form were answered she did not believe it was necessary to complete the Elopement Risk Assessment form. The Director of Nursing stated the first Elopement Risk Assessment was done on 6/29/18 because in the computer program the Elopement Risk Assessment had been opened on 6/29/18. She stated she was unable to know who performed the assessment due to the computer glitch. The Director of Nursing stated the resident was not at risk because only three of the fifteen questions were answered "yes." She further stated the second Elopement Risk Assessment was done 7/22/18, because of the date it was opened in the computer, after Resident #274 exited the facility unsupervised and was at risk for elopement and a wander guard was put in place.</p> <p>During observation on 8/8/18 at 2:00 PM, the parking lot where Resident #274 was found was observed. The approximate location Resident #274 was found was about 175 feet from the entrance to the facility. The location was approximately 50 feet away from a heavily traveled two-lane road with a 45 mile per hour speed limit. The edge of the parking lot, where Resident #110 had said Resident #274 was going, had a five-foot jagged edge in the cement. The edge dropped approximately three inches to the grass. The nearby road had a ditch along the road about 45 feet away from where the resident was approximately found.</p> <p>During an interview on 8/8/18 at 4:16 PM the Director of Nursing stated if Resident #274 had stated she was being taken out of the facility by a family member and had even almost convinced a nurse aide of this fact she would have expected</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>the concern to be documented and at least a new wandering assessment performed. She further stated no nurses or nurse aides had brought that concern to her attention and if it had happened she would have expected the staff to bring these issues to her attention and they did not. She further stated she had not been made aware that Resident #274 had attempted to leave the facility earlier in the day on 7/22/18 around 2 PM until 8/8/18.</p> <p>During an interview on 8/9/18 at 8:25 AM the Administrator stated on 7/22/18 at around 7 PM the Director of Nursing called him and informed him of Resident #274's unsupervised exit from the facility. He further stated the Director of Nursing informed him of the actions that had been taken. A wander guard was put in place after the resident had exited the facility and an elopement risk assessment was done. He further stated he was not familiar at that time with Resident #274's care and behaviors. The Administrator stated no staff had shared concerns with him that Resident #274 indicated she was leaving because family was picking her up. He further stated until 8/8/18 no staff had informed him that she had attempted to exit the facility earlier on 7/22/18 at about 2 PM. He further stated he did interview Resident #110 on 7/23/18 and he only shared with him the actual elopement and did not mention she had tried to leave the facility unsupervised earlier on 7/22/18. The Administrator concluded he let his Director of Nursing handle clinical concerns, however he felt a reasonable person would have placed a wander guard on Resident #274 following her first attempt to leave the facility and did not know why the House Supervisor did not.</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>During an interview on 8/9/18 at 9:30 AM Resident #274's Physician stated Resident #274 was very challenging behaviorally. He further stated Resident #274 was combative and resistive to care and had a history of dementia and psychiatric issues. He further stated she was alert with a degree of confusion. The Physician continued to state Resident #274 did not have good executive decision making abilities for certain decisions about her best interest. He further stated he had only had one visit with the resident and was not able to give further information about elopement risk because his other observations of the resident were when she was on the hall in passing.</p> <p>The Administrator and DON were notified of the immediate jeopardy on 8/8/18 at 12:35 PM. On 8/9/18 at 11:34 AM the facility provided the following credible allegation of compliance for immediate jeopardy removal:</p> <p>"Allegation of Compliance</p> <p>1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <ul style="list-style-type: none"> · Resident #274 was admitted to the facility on 6/29/18 and an Elopement Risk Assessment was completed. At that time, the resident was determined not to be an elopement risk because she never expressed a desire to leave the facility, she did not wander, and she had no exit-seeking behavior. FL-2 's from her previous facility indicated she was not a wanderer. · Nurse aide #1 reports that on an earlier date that she could not recall, the resident had previously indicated that she was planning to leave the facility and was redirected to her room. This was not reported to administration. It was 	F 689			

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F 689	<p>Continued From page 38 reported to the surveyor.</p> <ul style="list-style-type: none"> · Nurse #1 indicates that the resident was removed from being near the door at approximately 2:00 p.m. On 7/22/18 when an unrelated family member was leaving, the nurse cautioned the family not to let the resident out as they were holding the door open as if to let someone through. The nurse pulled the resident away from the door. The nurse did not report this to administration. She reported this to the surveyor. · At approximately 5:00 p.m., the charge nurse was notified by resident #1 that resident #274 was outside his window. Nurse #1 went outside and immediately returned her to the facility. · The resident was assessed for injury by charge nurse #1 and there was none. · A Wanderguard was placed on the resident on 7/22/18 by nurse #1 · The House Supervisor was immediately notified on 7/22/18 · The House Supervisor notified the DON and administrator on 7/22/18 · The resident ' s son was notified and he reported that she was just admitted to us from an ALF where she was permitted to and enjoyed sitting on the front porch outside. · A root cause analysis conducted on 7/23/18, revealed that the resident went out the front door after the receptionist left. The door had no staff member to monitor from 4:30-8:00 p.m. The root cause analysis to determine why administration was not notified of exit-seeking behavior found that staff indicated they did not notify administration because they did not see the resident try to exit the facility, she was known to make nonsensical statements, and staff felt as if they were monitoring the resident ' s activities. 	F 689			

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F 689	<p>Continued From page 39</p> <p>2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <ul style="list-style-type: none"> · Resident #274 had a new Elopement Risk Assessment completed on 7/23/18, a Wanderguard added on 7/22/18, and care plan updated 7/23/18. · On 7/24/18, a 100% audit was completed on all residents regarding the risk for elopement by the DON and ADON. There were no additional residents that were determined to be elopement risks. · An audit was conducted for all doors and Wanderguard bracelets and units on 7/23/18 to assess proper function by the Administrator. · On 7/24/18, an audit was completed on all care plans for those who wander on by the MDS Nurse. · On 7/23/18, a staff member was assigned to monitor the door after the receptionist leaves (from 4:30 pm-8:00 pm.) The door automatically locks from 8:00 pm to 8:00 a.m. · On 7/23/18, an order was placed for a remote buzzer/camera apparatus to allow the door to be visualized and unlocked from the nurse's station and/or lobby. The device will be installed as soon as available but the door will continue to be monitored by assigned staff when unlocked from 4:30 p.m.-8:00 a.m. · On 8/8/18 staff members (nurses, nurse aides, physical therapist, occupational therapist, speech language therapists, therapy assistants, department managers, dietary, housekeeping and laundry) were in-serviced on appropriate response to exit seeking behavior, notification of administration, and assignment of staff monitoring of door from 4:30-8:00 p.m. All nurses were in-serviced on proper completion of the Elopement Risk Assessment. No staff member 	F 689			

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F 689	<p>Continued From page 40</p> <p>will be permitted to return to work until they have been in-serviced.</p> <ul style="list-style-type: none"> · The QAA Committee and Medical Director met on 7/24/18 and 8/8/18 and approved this Allegation of Compliance. <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.</p> <ul style="list-style-type: none"> · The DON or ADON will review all new admission's Elopement Risk Assessments for accuracy weekly x 8, monthly x 2, and quarterly x3. · The DON or ADON will review all significant change Elopement Risk Assessments for accuracy weekly x8, monthly x2 and quarterly x3. · The Elopement Audit Tool will be completed monthly x4 and then quarterly x 3. · The QAA Committee will discuss all results monthly. <p>The Administrator, is responsible for this AOC and the credible allegation of compliance date is 8/8/18."</p> <p>The credible allegation for Immediate Jeopardy removal was validated on 8/9/18 at 12:30 PM, which removed the Immediate Jeopardy on 8/8/18, as evidenced by staff interviews, in-service record reviews, and observation. The in services included information on Resident #274's elopement risk, elopement risk assessments and how to complete them, and identification of residents who are at risk for elopement and what actions to take if a resident appears to be at risk for elopement. The in service also included information about having a door monitor during the times of the day the front door was unlocked.</p>	F 689			

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F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to remove 2 (two) expired medications (Hydralazine and Gas Relief) from the overflow stock supply drawers in 1 (one) of 1 medication storage room and failed to secure or label 7 unopened packets of medications (1 packet of Zinc Sulfate, 2 unopened packets of Clonidine, 3 unopened packets of Hydralazine, and 1 unopened packet of Hydroxyzine).</p>	F 761	<p>F761- Label/Store Drugs and Biologicals</p> <p>Criteria # 1: Two expired medications were identified in one medication storage area, in the overflow stock bins. Seven unopened individual doses were also identified in the overflow bins. It was determined that the Nurses</p>	8/20/18	

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F 761	<p>Continued From page 42</p> <p>Findings included:</p> <p>During a staff supervised observation of the medication storage room on 8/9/18 at 3:20 PM, 2 plastic container bins, each with 3 (three) drawers were observed on the counter of the medication storage room. Each drawer contained boxes and bottles of unopened medications, labeled with resident names. 1 bin was marked "200 West Overflow" and 1 bin was marked "200 East Overflow." The middle drawer of the 200 East Overflow bin contained 1 loose, unopened, and unlabeled packet of Zinc Sulfate 220 mg (milligrams) tablet, 2 loose, unopened, and unlabeled packets of Clonidine 0.1 mg tablets, 3 loose, unopened, unlabeled, and expired packets, with an expiration date of 7/18/18, of Hydralazine 12.5 mg tablets, and 1 loose, unopened, and unlabeled packet of Hydroxyzine 25 mg. The bottom drawer contained 1 bottle of 60 tablets of Gas Relief 125 mg which was marked with an expiration date of 7/4/18.</p> <p>An interview was conducted on 8/9/18 at 3:30 PM with Nurse #3 who stated she was responsible for the stock medications. She stated the hall nurses were responsible for checking the expiration dates on the overflow bin medications and then placed expired medications in the "return to pharmacy" bin located in the medication storage room. She also stated she was not aware of any one staff member being assigned to check for expired medications, but the expectation was for nurses to check the expiration dates on medications before they were administered.</p> <p>An interview was conducted with the Director of Nursing on 8/9/10 at 3:35 PM. She stated when stock or overflow medications were expired they</p>	F 761	<p>had not returned the expired and loose meds back to pharmacy. Expired meds and loose meds were written up and returned to pharmacy for credit and/or destruction. 08/09/18</p> <p>Criteria # 2: 100 % audit of all med rooms for expired meds and loose meds was completed by the Director of Nursing on 08/09/18.</p> <p>Criteria #3: 100% of all nurses and med aides were re-educated regarding the return of expired, discontinued meds, and loose meds to pharmacy. 08/20/18</p> <p>All newly hired Nurses and Med Aides will be educated during the Orientation process regarding the return of expired, discontinued meds, and loose meds to pharmacy. 08/20/18</p> <p>Criteria # 4: The Director of Nursing will assume responsibility of this POC and in her absence the Assistant Director of Nursing, RN Supervisor and/or Pharmacy Consultant will monitor Med rooms weekly x 4 weeks, Bi-monthly x 1 month and monthly x 2 months. The</p>		

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

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F 761	Continued From page 43 were pulled, written up on a sheet and sent back to pharmacy to be destroyed or credited back. She stated this was typically completed by the 25th of every month. She also stated the consultant pharmacist or any team leader or designee checked the medication room for expired medications. She also stated medications, not labeled with a resident name, should not be loose in the drawers. She stated her expectation was the medication storage room would not contain any expired medications or medications not labeled with a resident name.	F 761	Director of Nursing will incorporate the POC into the facility's monthly QAA meeting to evaluate effectiveness and compliance with the regulatory requirements. 08/20/18	