

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

PRINTED: 06/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/23/2019
NAME OF PROVIDER OR SUPPLIER BLADEN EAST HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 804 S POPLAR STREET ELIZABETHTOWN, NC 28337		
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E 000	Initial Comments	E 000			
F 656 SS=D	<p>An unannounced Recertification/Complaint investigation survey was conducted on 05/19/19 through 05/23/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#P28N11</p> <p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and</p>	F 656		6/19/19	

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

TITLE

(X6) DATE

Electronically Signed

06/07/2019

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

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F 656	<p>Continued From page 1</p> <p>desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interviews, the facility failed to implement and intervention in the current care plan to obtain weekly weights for 4 weeks for 1 of 3 residents (Resident #218) observed for weight loss.</p> <p>Findings included:</p> <p>Resident #218 was admitted to the facility on 09/01/16. Diagnoses included, in part, Cerebral infarction (stroke), hemiplegia (impairment to one side), congestive heart failure (CHF), coronary heart disease, and diabetes.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 05/15/19 revealed the resident was severely cognitively impaired. Resident #218 was independent with set up only for meals and had impairment on one side to upper and lower extremity and used a wheelchair. Resident #218 's weight was coded as 199 lbs., had a 5% weight lost in the last month, and was not on a prescribed weight loss regimen. Resident #218 was coded for a therapeutic diet, did not have any swallowing issues, and received two days of a diuretic medication (a medication to remove</p>	F 656	<ol style="list-style-type: none"> 1. Resident #218 physician was notified on 5/29/19 of weekly weights not being obtained as ordered. Physician was also notified of current weights of 205.8 on 5/23/19 and 205.4 on 5/29/19. New order was received on 5/29/19 to continue weekly weights. Intervention was continued on resident care plan and on resident medication administration record for documentation. 2. Residents with physician's orders for weekly weights have the potential to be affected by same deficient practice. Residents with current orders for weekly weights were identified through review of current physician orders. Care plans for these identified residents were reviewed to ensure weekly weights were noted on current interventions. Weight records for identified residents were reviewed to validate weekly weights were obtained as stated in care plan and physician orders. 3. Licensed staff will be in-serviced by the Director of Nursing on facility process for obtaining and recording weekly weights and implementation of care plan 		

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F 656	<p>Continued From page 2 excess fluid from the body).</p> <p>A review of Resident #218 ' s care plan revealed an updated plan of care dated 05/09/19. Resident #218 had a plan of care for potential nutritional problems related to current no concentrated sweet (NCS) diet that may affect intake. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 10% of current body weight, no signs or symptoms of malnutrition, and consuming at least 50% of at least 3 meals daily through review date. The interventions included, in part, to provide and serve diet as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations and weekly weights X 4 weeks every Wednesday on day shift.</p> <p>A review of the physician orders written on 05/06/19 revealed an order to obtain weekly weights for 4 weeks every Wednesday.</p> <p>A record review revealed there was an order on the MAR for weekly weights on Wednesdays at 6:00 PM, however, only one weight was documented on 05/10/19. There was no weight documented for Wednesday, 05/15/19 or Wednesday, 05/22/19.</p> <p>A record review of the weights recorded in the computer revealed the last weight obtained for Resident #218 was on 05/10/19 with a weight of 198.8 lbs.</p> <p>A review of the Dietician Nutritional risk note written on 05/20/19 revealed the resident was placed on NSA (no sugar added) mighty shakes three times daily for weight stability and to provide</p>	F 656	<p>interventions. The Unit Manager or designee will maintain a list of residents with active orders for weekly weights. Weekly weights will be obtained on Tuesday each week, noted on the medication administration record by the staff nurse, and recorded in Point Click Care by the Unit Manager. The Unit Manager or designee will update resident care plans when new weekly weight orders are received or when weekly weight orders are discontinued.</p> <p>4. The Director of Nursing will complete an audit of the weekly weight list, validate weights are obtained as ordered, and ensure care plan interventions for weekly weights are implemented. Audits will be done weekly x 4 weeks, then monthly x 2 months. Results of these audits will be reviewed by the facility's QA committee monthly x 3 months or until consistent compliance is identified.</p>		

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F 656	<p>Continued From page 3</p> <p>18 gm (grams) supplemental protein to help replete his visceral protein stores. The note indicated the Dietician would continue to monitor his oral intakes and would follow up as indicated. The note further indicated no current weight was available.</p> <p>An interview was conducted with NA #3 on 05/22/19 at 10:45 AM. NA #3 stated the process for obtaining weights was the nurse would let them know at the beginning of their shift who needed a weight for that day. NA #3 stated she would weigh the resident and report the weight to the nurse. If the nurse instructed NA #3 to get a reweigh, she would reweigh the resident and let the nurse know, again, what the weight was.</p> <p>An interview was conducted with Nurse #7 on 05/22/19 at 2:30 PM. Nurse #7 stated if there was an order for weekly weights, the order would appear on the MAR or TAR and the nurse would be responsible for obtaining the weight and documenting it on the record. Nurse #7 stated the nursing assistants would weigh the resident and let the nurse know what the weight was so they could record it on the MAR or TAR and in the computer system under weights.</p> <p>A review of the MAR and the weight log in the computer system was done on 05/23/19 at 9:00 AM. The weight for 05/22/19 was not recorded on the MAR or in the weight section of the computer system.</p> <p>An interview was conducted with the RD via phone on 05/23/19 1:30 PM. The RD reported she would have expected the order of obtaining the weights to be carried out as written due to his diagnosis of CHF and weight loss and to see if</p>	F 656			

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F 656	Continued From page 4 the mighty shakes were helping with his weight loss. An interview was conducted with the DON on 05/23/19 at 1:40 PM. The DON reported her expectation would be that the nurse ' s obtained the weekly weights as ordered.	F 656			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, nurse practitioner (NP) interview, staff interview, and record review the facility failed to follow a physician order to obtain weekly labs for 1 of 5 sampled residents (Resident #35) reviewed for unnecessary medications and failed to obtain a physician order for 1 of 1 sampled residents (Resident #217) who was observed wearing compression stockings. Findings included: 1. Record review revealed Resident #35 was admitted on 09/30/18. The resident's documented diagnoses included hypertension, congestive heart failure, chronic obstructive pulmonary disease, diabetes, chronic pain syndrome, and anxiety. 10/02/18 lab results documented Resident #35's hemoglobin was 11.7 grams per deciliter (g/dL), with normal being 12 - 16 g/dL), and Resident #35's hematocrit was 34.8%, with normal being	F 658	1. Resident #217 no longer in facility. Resident #35 physician was notified on 5/15/19 of lab omissions. New order was given to obtain H&H on 5/16/19 and H&H was obtained this date. 2. Residents requiring use of compression stockings and with physician orders for weekly labs have the potential to be affected by same deficient practice. A. Current residents using compression stockings were identified by visual inspection and by review of current physician orders. Physician orders for identified residents were reviewed to validate current orders were in place for compression stockings. B. Lab audit was completed for the past 30 days (5/1/19-6/1/19) to identify labs not obtained as ordered. No further omissions were identified. 3. A. Licensed staff will be in-serviced by	6/19/19	

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F 658	<p>Continued From page 5 37 - 47%.</p> <p>The resident's 03/31/19 quarterly minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she was independent with her activities of daily living, she was always continent of bowel and bladder, and she had no wounds.</p> <p>04/04/19 lab results documented Resident #35's hemoglobin was 7.5 g/dL, with normal being 12 - 16 g/dL, and Resident #35's hematocrit was 24.2%, with normal being 37 - 47%.</p> <p>04/09/19 lab results documented Resident #35's hemoglobin was 7.5 g/dL, with normal being 12 - 16 g/dL, and Resident #35's hematocrit was 24.4%, with normal being 37 - 47%.</p> <p>A 04/10/19 3:53 PM progress note documented, "Seen by ____ (name of primary physician) today with new orders noted....3) Obtain H & H (hemoglobin and hematocrit) weekly starting on 04/16/19...Lab requisition done for labs." The primary physician wrote the order to draw weekly H & H labs on 04/10/19, and the order was present in the resident's medical record.</p> <p>Review of Resident #35's medical record revealed there were no H & H values obtained for the resident between 04/10/19 and 05/15/19.</p> <p>A 04/17/19 physician progress note documented: "...Resident noted to have had a drop in her hemoglobin from 11 down to 7. I requested for her to have H & H weekly x 3. Results from yesterday are not available for review. Requested for resident to have iron studies. She was found to have iron deficiency and significant</p>	F 658	<p>the Director of Nursing on identification of compression stockings upon admission, obtaining physician order for use of compression stockings, and appropriate documentation for use of compression stockings. Admitting Nurse will note on admission assessment if compression stockings are noted on resident, contact physician for order if not present on admission orders, and place order in Point Click Care to print on treatment administration record for documentation of on/off times. The Director of Nursing will maintain a current list of residents with physician orders for use of compression stockings, review new admission assessments for use of compression stockings, and validate appropriate physician orders in Point Click Care.</p> <p>B. Licensed staff will be in-serviced on facility process for scheduling and obtaining weekly labs. Weekly lab orders will be entered into Point Click Care as a routine lab order by the licensed nurse receiving the order from the physician. The order will be printed on an administration record which will be kept with the resident's medication administration record and will be signed off by the licensed nurse once the lab has been obtained.</p> <p>4. A. The Director of Nursing will audit the treatment administration records weekly x 4 weeks, then monthly x 2 months to validate compression stockings on/off times are signed off as ordered.</p> <p>B. The Director of Nursing will audit the medication administration records weekly x 4 weeks, then monthly x 2</p>		

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F 658	<p>Continued From page 6</p> <p>B-12 deficiency with normal folate level....Assessment: Anemia: unclear etiology. Status post Hemocult negative, recently I discontinued her aspirin, I also discontinued her Plavix (both discontinued 04/04/19), she is on proton pump inhibitor twice daily, she is on iron supplementation twice daily with vitamin C, she was started on vitamin B-12 injections 1,000 micrograms weekly x 4 and then monthly, she has instructions for follow-up B-12 level, reassess resident in about 4 weeks. Despite her comorbidities I am going to continue to hold her antiplatelet therapy given her significant drop in hemoglobin of unclear etiology and reassess in the near future."</p> <p>A 04/17/19 3:54 PM progress note documented, "Resident seen by ____ (name of primary physician) today with new order to follow up with him on 05/15/19...."</p> <p>A 05/15/19 physician progress note documented, "...Recent encounter secondary to drop in hemoglobin where I had requested resident to have hemoglobin and hematocrit weekly x 4 iron studies and to reassess resident in 4 weeks. Unfortunately her weekly laboratories do not appear to have been drawn...."</p> <p>A 05/15/19 12:46 PM progress note documented, "____ (name of primary physician) in today to see resident and verbal order received to obtain H and H on 05/16/19 and follow-up with Nurse Practitioner (NP) next week."</p> <p>05/16/19 lab results documented Resident #35's hemoglobin was 6.8 g/dL, with normal being 12 - 16 g/dL, and Resident #35's hematocrit was 22.8%, with normal being 37 - 47%.</p>	F 658	<p>months to validate weekly labs are obtained and signed off as ordered.</p> <p>Results of these audits will be reviewed by the facility's QA committee monthly x 3 months or until consistent compliance is identified.</p>		

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F 658	<p>Continued From page 7</p> <p>A 05/16/19 12:20 PM progress noted documented, "Nurse called (NP) regarding H & H results. New order to send to hospital as outpatient for type and cross and 2 units of blood for transfusion, due to (hemoglobin) of 6.8."</p> <p>A 05/16/19 2:30 PM progress note documented a hospital nurse called the nursing home to inform staff that Resident #35's hemoglobin was 8.7 g/dL (and hematocrit was 24.8%) when drawn in the emergency room (ER). "Resident will be transferred back to facility."</p> <p>During an interview with the NP on 05/21/19 at 2:40 PM she stated if she or the physician wrote an order to draw labs then she expected the facility to follow through and obtain the labs so the information could be used in making healthcare decisions for residents.</p> <p>During an interview with Nurse #7 on 05/22/19 at 2:10 PM she stated she could write telephone lab orders or the physicians sometimes wrote their own lab orders, the Assistant Director of Nursing (ADON) put the orders into the electronic system, staff drew STAT labs and lab technicians drew other labs, lab results were faxed to the facility's main fax machine, and the unit manager distributed the faxes. She reported if she had not received lab results in about 2 - 3 days she would call the lab to see what the problem was.</p> <p>During an interview with Nurse #2, an Unit Manager, on 5/22/19 at 2:27 PM she stated the nurse who took the lab order put them into the electronic system under the lab tab. She reported the ADON kept a lab notebook, and Tuesday and Thursday were the facility's lab</p>	F 658			

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F 658	<p>Continued From page 8</p> <p>days. She commented the ADON checked each morning for new lab orders. She explained lab techs drew labs on lab days, and direct care staff drew STAT labs. According to Nurse #2, lists of labs to be drawn each day were kept in three places: at the fax machine and each of the two nursing stations. She remarked sometimes as a unit manager she would distribute lab results. The Unit Manager reported by the next morning if no lab results were obtained then a staff member should make contact with the lab to find out why no results had been received (unless the facility was waiting on C & S results which would take longer to obtain). She stated she was not sure what caused the problem with collecting weekly H & H labs for Resident #35.</p> <p>During an interview with the ADON on 5/22/19 at 4:02 PM she stated she could not explain how the weekly H & H lab draws for Resident #35 got missed. However, she reported the physician realized that the labs were missed, and the resident exhibited no side effects. She explained Resident #35 was sent out to the ER for transfusion based on the hemoglobin value the facility obtained on 05/16/19. However, she commented when the resident got to the ER the ER drew its own lab which found the resident's hemoglobin to be 8.7. According to the ADON, she did not think the hospital transfused unless the hemoglobin was below 7.</p> <p>During an interview with the Director of Nursing (DON) on 05/23/19 at 2:07 PM she stated she expected labs to be drawn per physician orders.</p> <p>2) Resident #217 was admitted to the facility on 05/02/19 and discharged to the hospital on</p>	F 658			

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F 658	<p>Continued From page 9</p> <p>05/19/19. Diagnoses included, in part, status post closed fracture of neck of femur, congestive heart failure, diabetes, coronary artery disease and peripheral vascular disease.</p> <p>The MDS 5-day assessment dated 05/09/19 revealed the resident was moderately cognitively impaired with no moods or behaviors indicated. Resident #217 required total dependence with two staff physical assistance with bed mobility, transfers and dressing, total dependence with one staff physical assistance with locomotion on the unit, independent with set up only with meals, total dependence with two staff physical assistance with toileting, and extensive assistance with one staff physical assistance with personal hygiene. Resident #217 had an impairment to one side to the lower extremity, used a walker and a wheel chair, had an indwelling urinary catheter and was always incontinent of bowel. He was coded as having a surgical wound.</p> <p>A review of all of the physician orders, Medication Administration Record (MAR), Treatment Administration Record (TAR) as well as the hospital discharge instructions from 05/02/19 revealed there were no orders to apply compression stockings (ted stockings) on Resident #217.</p> <p>An interview was conducted with Nurse #1 on 05/20/19 at 3:30 PM. Nurse #1 worked on 05/12/19 and 05/13/19. Nurse #1 reported she was familiar with Resident #217 and recalled the day she identified the resident 's deep tissue injury to his heel. Nurse #1 reported she was informed by the nursing assistant (NA) that there was blood on his bed and it looked like he was</p>	F 658			

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F 658	<p>Continued From page 10</p> <p>bleeding from his heel. Nurse #1 reported she noted the resident had on ted stockings and blood was oozing from the ted stocking. She removed the teds stocking and noted there was a large dark purplish area that was not raised, noted to be bleeding and the resident complained of pain. She stated she cleaned it up and put skin prep on it and reapplied the ted stocking. Nurse #1 reported there was no order for the stockings and stated the resident was admitted with the "ted hose" on. Nurse #1 stated she noted they were on the resident when she did her initial head to toe assessment upon admission. Nurse #1 stated she did not do the admitting orders, the Unit Manager did them, and she assumed there was an order for them. Nurse #1 reported if a resident had ted stockings and was wearing them, there should be an order to apply in the morning and remove in evening. Nurse #1 stated the NAs would usually apply the teds and the nurse ' s check to see if they are on and then document in the MAR or TAR, but they were not on the MAR or TAR because there was no order.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) on 05/21/19 at 4:45 PM. The ADON reported she recalled Resident #217 wearing ted stockings.</p> <p>An interview was conducted with NA #3 on 05/22/19 at 10:45 AM who worked on 05/09/10, 05/12/19, and 05/13/19. NA #3 reported she recalled Resident #217 and she assisted him to the shower on 05/09/19 via a wheelchair. NA #3 reported Resident #217 had his ted stockings on and she removed them prior to the shower. NA #3 stated on Saturday 05/12/19 she went to see the resident to get him up for his shower and she noted there was blood on the bed under his right</p>	F 658			

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F 658	<p>Continued From page 11</p> <p>heel. She stated she told Nurse #1 and the nurse removed his ted stocking and cleaned up the wound on his heel. NA #3 reported she noted the resident had his ted stockings on when she came in in the morning on 05/12/19 and 05/13/19.</p> <p>An interview was conducted with the Director of Therapy (DOT) on 05/22/19 at 3:20 PM. The DOT confirmed Resident #217 was on therapy caseload and recalled that he wore ted stockings to his bilateral feet as she remembered placing nonskid socks over the ted stockings to assist with transfers safely.</p> <p>An interview was conducted with the Unit Manager (UM) on 05/23/19 at 10:20 AM. The UM reported she did the admission orders for Resident #217 on 05/02/19. The UM stated the process of implementing orders from the hospital discharge records was to call the physician to verify the discharge orders. Once the orders were verified, the orders were then put into the computer system which would generate a MAR based on the orders that were put in the system. The UM reported there were no orders for the ted stockings and if the resident came in with them applied, the nurse should have called the physician to verify if the physician wanted the resident to continue to use the ted stockings and then put an order in place.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/23/19 at 11:00 AM. The DON reported her expectation for the nurses were to call and verify if the resident should continue to wear the ted stockings he was admitted with and obtain an order if the physician felt the resident should continue to be wearing them. The DON reported the ted stockings</p>	F 658			

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F 658	Continued From page 12 application should have been on the MAR or TAR to apply in the morning and remove in the evening.	F 658			
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 record reviews, staff, Nurse Practitioner (NP), and Emergency Medical Service (EMS) interviews, the facility transferred a resident with a visible injury from the floor to the bed prior to the arrival of Emergency Medical Services (EMS) following a fall in the facility for 1 of 3 sampled residents reviewed for falls (Resident #19). Findings included: Resident #19 was admitted to the facility on 05/24/18 and re-admitted 05/13/19 and discharged to the hospital 05/15/19 with a cumulative diagnoses including: dementia, major depression, and anxiety. Resident #19 ' s Minimum Data Set (MDS) dated 03/11/19 documented that the resident had severe cognitive impairments. The resident needed total assistance for personal hygiene, and	F 684	1. NA #1 (assigned to resident #19) received 1:1 in-servicing initially post fall on 5/9/19 on Caring for Residents with Agitation and again on 5/22/19 to include post fall management and not moving a resident with visible injury until assessed by a nurse and/or EMS. 2. Residents experiencing a fall with visible injury in the facility have the potential to be affected by same deficient practice. 3. Nursing staff will be in-serviced by the Director of Nursing on post fall management and not moving resident post fall if injury is visible until assessed by nurse and/or EMS. Licensed staff will be in-serviced to document in resident progress note that resident was not moved from position noted post fall for all falls with visible injury. 4. The Director of Nursing or designee	6/19/19	

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F 684	<p>Continued From page 13</p> <p>one person physical assistance for all her other activities for daily living (ADLs).</p> <p>Resident #19 ' s care plan goals dated 03/07/19 documented: Resident had an ADL self-care performance deficit related to dementia. Resident was totally dependent on 1 staff assist to provide bath/shower, personal hygiene, and transferring. Resident #19 was at risk for falls related to cognitive impairment.</p> <p>A nursing note dated 05/08/19 at 9:55 PM revealed Nurse #3 was called into Resident #19 ' s room at 9:15 PM by Nurse Aide (NA) #1. Resident was observed lying on her right side on the floor. The NA #1 stated that she was cleaning resident and reached for wipes and quickly heard a thump and resident had fallen off of the bed; but, she did not see it happen, it was so quick. Resident ' s right leg was noted to have edema and she had an area in the middle of her forehead, noted to be slightly swollen. The resident stated, her leg and her head was hurting. The resident also had an episode of vomiting. Nurse #3, called 911 at 9:20 PM and then immediately notified Nurse Practitioner (NP) #1, who was in agreement to send resident to the hospital.</p> <p>An interview conducted with NA #1 on 05/21/19 at 3:28 PM revealed that on 05/08/18 around 9:15 PM Resident #19 fell out of bed while she was doing her incontinent care. NA #1 said Resident #19 was laying on her left side in bed, and she was holding the resident ' s hand with her left hand. She said with her right hand she was trying to pull the wipes out of the pack when 3 or 4 got stuck together in the pack. The NA said when she let go of the resident ' s hand with her left</p>	F 684	will review each fall with injury to ensure residents were not moved prior to being assessed by the nurse and/or EMS. Falls with injury will be reviewed by the facility's QA committee monthly to ensure continued compliance.		

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F 684	<p>Continued From page 14</p> <p>hand in order to get the stuck wipes out of the container, the resident pushed herself off the wall with her foot and flipped quickly out of the bed onto the floor. NA #1 said she immediately went to the nursing station to get a nurse. She commented Nurse # 3, was the first to show up, assessed the resident on the floor, and then left to call the MD and Responsible Party (RP), leaving her and two other nurses with the resident. She stated the second nurse, Nurse #4 helped to calm the resident, and then left to take care of her own patients. She reported the third nurse, Nurse #5 told me to clean up the resident before EMS showed up, and left to get a draw sheet to put under the resident for transport. The NA said, she alone picked up the resident from behind her arms and put her in the bed. She said, she moved the resident to the bed, because there was stool/urine on the floor, and that the bed would be a better place than the floor to clean up the resident. The NA said, if she could do it all over again, she would not have moved the resident, and would have just left her on the floor until EMS arrived.</p> <p>An interview on 05/21/19 at 4:23 PM with Nurse #3 revealed that on 05/08/19 around 9:15 PM, NA #1 called her into Resident #19 ' s private room and found the resident on her right side on the floor by her bed. The nurse said while she was assessing the resident, the resident was trying to get back into her bed from the floor. She said, she tried to make the resident comfortable, and put a pillow under her head. The nurse said she left to call 911 and the MD, leaving NA #1 with the resident on the floor. She said she told staff who were present in the resident ' s room, you cannot move a resident with a head and leg injury, and not to move the resident until EMS showed up.</p>	F 684			

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F 684	Continued From page 15 An interview on 05/22/19 at 5:00 PM with Nurse #5 revealed on 05/08/19 she observed Resident #19 laying on her right side on the floor, next to her bed. She said when she when she first observed the resident it was obviously apparent her leg was broken, and she told NA #1 not to move the resident, and to leave her on the floor. She said she then went to get a draw-sheet to put under the resident. She said when she returned with the draw-sheet, she found the resident in her bed. The nurse said NA #1 should not have moved the resident. An Emergency Medical Services (EMS) Report dated 05/08/19 revealed EMS arrived on scene at 9:39 PM to find NA #1 and nursing staff in Resident #19 ' s room. Patient was laying semi-fowlers in nursing home bed. Patient ' s right leg was bent towards her and her thigh, on the right side was deformed. Patient ' s skin was warm and dry. Patient was wearing only an adult brief. Nursing home bed was up at its highest position. They found the patient laying on the floor with her right leg folded up behind her. EMS staff were told that staff picked the patient up and placed her back on the bed, where EMS crew found the patient. Patient was moved via draw-sheet, secured. An interview on 05/22/19 at 12:20 PM with EMS #1 revealed when she first saw Resident #19 in room on 08/05/19 at 9:39 PM Resident #19 was lying in bed, with a blanket pulled up to her chin. She said when she ask what happened, she was told that the resident fell out of bed while NA #1 was changing her. She said the resident ' s right leg showed extensive deformity. The resident was in pain, vomited, and had a hematoma to the	F 684			

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F 684	<p>Continued From page 16</p> <p>head. She was told that the resident ' s bed was up, while the NA was changing her, and that she rolled out of bed, folding her leg. She said the facility staff should not have moved the resident from the floor to the bed. The NA told her that she moved the resident to the bed. The NA told her that she freaked out, when she saw the resident on the hard cold floor.</p> <p>A Hospital History and Physical (H&P) dated 05/09/19 at 3:47 AM revealed per Emergency Medical Services (EMS), for evaluation of right leg pain following a fall. Per EMS the facility staff report documented Resident #19 was on the bed at the high setting getting her adult brief changed. Subsequently she was found on the floor. The patient was placed back on the bed prior to EMS arrival. A Cartography Scan (CT) of Resident #19 ' s head without contrast was negative for acute changes other than the scalp hematoma/contusion. An x-ray of her right femur showed acute fracture of the proximal right femoral shaft.</p> <p>A facility Nurse Practitioner (NP) #1 interviewed dated 05/21/19 at 2:30 PM revealed on 05/08/19 NA #1 should not have moved Resident #19 from the floor to the bed before an assessment by EMS was conducted. NP #1 said NA #1 should have kept the resident still until EMS showed up.</p> <p>An interview conducted with the Director of Nursing (DON) on 05/22/19 at 12:10 PM revealed it was her expectation, if a resident fell with an apparent body or head injury, the nursing staff would not move the resident until an EMS assessment was done on the resident. Staff would then keep the resident comfortable on the floor, encourage the resident to wait where they</p>	F 684			

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F 684	Continued From page 17 were, and wait for EMS assistance. An interview on 05/22/19 at 2:30 PM with the Therapy Director revealed if any resident was found on the floor, no one should put the resident back to bed if there is a visible injury. She said nursing staff should assess the resident, keep them comfortable on the floor, keep the resident comfortable, and stay with the resident until EMS arrived.	F 684			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to; 1) transcribe an	F 692	1. Resident #218 Mighty Shake TID with meals order was added to the Medication	6/19/19	

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F 692	<p>Continued From page 18</p> <p>ordered supplement for 1 of 3 residents (Resident #218) observed for weight loss and; 2) failed to follow an order that was in place to obtain weekly weights for 4 weeks for 1 of 3 residents (Resident #218) observed for weight loss.</p> <p>Findings included:</p> <p>Resident #218 was admitted to the facility on 09/01/16. Diagnoses included, in part, Cerebral infarction (stroke), hemiplegia (impairment to one side), congestive heart failure (CHF), coronary heart disease, and diabetes.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 05/15/19 revealed the resident was severely cognitively impaired. Resident #218 was independent with set up only for meals and had impairment on one side to upper and lower extremity and used a wheelchair. Resident #218 ' s weight was coded as 199 lbs., had a 5% weight lost in the last month, and was not on a prescribed weight loss regimen. Resident #218 was coded for a therapeutic diet, did not have any swallowing issues, and received two days of a diuretic medication (a medication to remove excess fluid from the body).</p> <p>A review of Resident #218 ' s care plan revealed an updated plan of care dated 05/09/19. Resident #218 had a plan of care for potential nutritional problems related to current no concentrated sweet (NCS) diet that may affect intake. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 10% of current body weight, no signs or symptoms of malnutrition, and consuming at least 50% of at least 3 meals daily through review date. The interventions included,</p>	F 692	<p>Administration Record 6/1/19 and to the tray card on 5/23/19. Resident #218 physician was notified on 5/29/19 of weekly weights not being obtained as ordered. Physician was also notified of current weights of 205.8 on 5/23/19 and 205.4 on 5/29/19.</p> <p>2. Residents with orders for meal supplements and weekly weights have the potential to be affected by same deficient practice. Residents with current orders for meal supplements were identified through review of current physician orders. Tray cards were then audited for identified residents to validate accuracy. Medication Administration Records were audited for identified residents to validate supplements were documented. Residents with current orders for weekly weights were identified through review of current physician orders. Weight records for identified residents were reviewed to validate weekly weights were obtained as stated in physician orders.</p> <p>3. Licensed staff will be in-serviced by the Director of Nursing on completion of dietary communication slip for notification of dietary staff for supplement orders, addition of supplement orders to the medication administration record, validation of meal supplements, and facility process for obtaining and recording weekly weights. Dietary Manager and Director of Nursing will review residents with new orders to receive supplements weekly to ensure orders are current, printed on the tray cards, and printed on the Medication Administration Record. The Dietary Manager will maintain a</p>		

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F 692	<p>Continued From page 19</p> <p>in part, to provide and serve diet as ordered, Registered Dietician (RD) to evaluate and make diet change recommendations and weekly weights X 4 weeks every Wednesday on day shift.</p> <p>1) A review of the physician orders written on 05/06/19 revealed an order for mighty shake supplements with all meals.</p> <p>A record review revealed there was a written diet order and communication slip for mighty shakes with all meals dated 05/07/19 signed by the Unit Manager (UM).</p> <p>A record review of the May Medication Administration Record (MAR) revealed there was no order for mighty shakes with all meals on the MAR.</p> <p>A review of the Dietician Nutritional risk note written on 05/20/19 revealed the resident was placed on NSA (no sugar added) mighty shakes three times daily for weight stability and to provide 18 gm (grams) supplemental protein to help replete his visceral protein stores. The note indicated the Dietician would continue to monitor his oral intakes and would follow up as indicated. The note further indicated no current weight was available.</p> <p>A lunch observation was conducted for Resident #218 in the dining room on 05/21/19 at 12:50 PM. The lunch tray was placed in front of the resident and there was no mighty shake on the lunch tray. The resident was observed until 1:15 PM and at no time was a mighty shake placed on his tray. The resident was observed not eating and when asked if he was going to eat he shook his head,</p>	F 692	<p>current list of residents receiving supplements.</p> <p>The Unit Manager or designee will maintain a list of residents with active orders for weekly weights. Weekly weights will be obtained on Tuesday each week, noted on the medication administration record by the staff nurse, and recorded in Point Click Care by the Unit Manager.</p> <p>4. The Director of Nursing or designee will audit 10 meal trays weekly x 4 weeks, then 10 meal trays monthly x 2 months to ensure supplements are provided as ordered. The Director of Nursing will complete an audit of the weekly weight list and validate weights are obtained as ordered. Audits will be done weekly x 4 weeks, then monthly x 2 months. Results of these audits will be reviewed by the facility's QA committee monthly x 3 months or until consistent compliance is identified.</p>		

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F 692	<p>Continued From page 20</p> <p>"no." When asked if he liked what was being served, he shook his head, "no." A staff member then asked if he would like something else and he shook his head, "no." The resident was noted to have consumed about 120 milliliters (mls) of his beverage which was recorded on his dietary ticket as tea. A review of the resident ' s dietary ticket on his meal tray revealed there was no order for mighty shakes with each meal displayed on the ticket.</p> <p>A lunch observation was conducted for Resident #218 in the dining room on 05/22/19 at 12:53 PM. The lunch tray was placed in front of the Resident and there was no mighty shake on his lunch tray. The lunch tray was noted to have the main entrée and two cups of ice cream on it. A staff member was observed standing beside him and encouraging him to eat. The resident was observed eating one of the ice cream cups. A review of the resident ' s dietary ticket on his meal tray revealed there was no order for mighty shakes with each meal displayed on the ticket.</p> <p>An interview was conducted with Nurse #7 on 05/22/19 at 2:30 PM. Nurse #7 reported if there was an order for mighty shakes or any kind of supplement it would appear on the MAR so that the nurse can document that it was given. Nurse #7 stated Resident #218 did not have a very good appetite and would need a lot of encouraging to eat but he would do better with his beverages than he did with his solid food intake.</p> <p>A dinner observation was conducted for Resident #218 in his room on 05/22/19 at 6:20 PM. The dinner tray was observed being placed in front of the resident on his bed side table. There was no mighty shake on the tray. The resident was</p>	F 692			

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

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F 692	<p>Continued From page 21</p> <p>observed consuming his beverage, however he was not eating his entrée. A review of the resident ' s dietary ticket on his meal tray revealed there was no order for mighty shakes with each meal displayed on the ticket.</p> <p>An observation of the tray was conducted with the Dietary Manager (DM) on 05/22/19 at 6:30 PM. The DM confirmed there was no mighty shake on the tray and further added he had not been receiving mighty shakes because there was no order. The DM reviewed the dietary ticket and stated if there had been an order, it would have been on the dietary ticket. The DM stated when there was an order for a supplement, the nursing staff would fill out a diet slip and hand deliver it to her in the dining room. The DM stated at that time, she would in put the order in the computer and the order would appear on the dietary ticket for staff to know that a mighty shake should be on each meal tray.</p> <p>An interview was conducted with the UM on 05/23/19 at 9:45 AM. The UM reviewed the diet slip for Resident #218 and confirmed she had written the diet slip for mighty shakes three times daily for Resident #218. The UM reported when she had an order for dietary, she would put the order in the computer system, print the order for physician signature and print the MAR. She would then fill out the diet slip and bring to the DM. The UM stated once the order was in the computer it would generate to the MAR. The UM reviewed the MAR with Nurse #8 and found there to be no order for mighty shakes on the MAR. The UM was not sure why the order was not transcribed on to the MAR.</p> <p>An interview with Nurse #8 on 05/23/19 at 9:50</p>	F 692			

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F 692	<p>Continued From page 22</p> <p>AM revealed she did not recall an order for mighty shakes. Nurse #8 stated she has not given any mighty shakes to Resident #218.</p> <p>An interview was conducted with the RD via phone on 05/23/19 1:30 PM. The RD reported she had ordered mighty shakes three times daily since Resident #218 was not eating well and he was better with fluid intake. The RD stated the mighty shakes would give the resident 54 grams of protein total and if he consumed just 25% of the shakes, it would help with his health maintenance. The RD stated she would have expected the nurses to transcribe the order and administer the mighty shakes as ordered.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/23/19 at 1:40 PM. The DON reported her expectation would be that the nurse 's transcribed the order for the mighty shakes as written so that they would be administered.</p> <p>2) A review of the physician orders written on 05/06/19 revealed an order to obtain weekly weights for 4 weeks every Wednesday.</p> <p>A record review revealed there was an order on the MAR for weekly weights on Wednesdays at 6:00 PM, however, only one weight was documented on 05/10/19. There was no weight documented for Wednesday, 05/15/19 or Wednesday, 05/22/19.</p> <p>A record review of the weights recorded in the computer revealed the last weight obtained for Resident #218 was on 05/10/19 with a weight of 198.8 lbs.</p>	F 692			

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F 692	<p>Continued From page 23</p> <p>A review of the Dietician Nutritional risk note written on 05/20/19 revealed the resident was placed on NSA (no sugar added) mighty shakes three times daily for weight stability and to provide 18 gm (grams) supplemental protein to help replete his visceral protein stores. The note indicated the Dietician would continue to monitor his oral intakes and would follow up as indicated. The note further indicated no current weight was available.</p> <p>An interview was conducted with NA #3 on 05/22/19 at 10:45 AM. NA #3 stated the process for obtaining weights was the nurse would let them know at the beginning of their shift who needed a weight for that day. NA #3 stated she would weigh the resident and report the weight to the nurse. If the nurse instructed NA #3 to get a reweigh, she would reweigh the resident and let the nurse know, again, what the weight was.</p> <p>An interview was conducted with Nurse #7 on 05/22/19 at 2:30 PM. Nurse #7 stated if there was an order for weekly weights, the order would appear on the MAR or TAR and the nurse would be responsible for obtaining the weight and documenting it on the record. Nurse #7 stated the nursing assistants would weigh the resident and let the nurse know what the weight was so they could record it on the MAR or TAR and in the computer system under weights.</p> <p>A review of the MAR and the weight log in the computer system was done on 05/23/19 at 9:00 AM. The weight for 05/22/19 was not recorded on the MAR or in the weight section of the computer system.</p> <p>An interview was conducted with the RD via</p>	F 692			

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F 692	Continued From page 24 phone on 05/23/19 1:30 PM. The RD reported she would have expected the order of obtaining the weights to be carried out as written due to his diagnosis of CHF and weight loss and to see if the mighty shakes were helping with his weight loss.	F 692			
F 867 SS=D	An interview was conducted with the DON on 05/23/19 at 1:40 PM. The DON reported her expectation would be that the nurse ' s obtained the weekly weights as ordered. QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implementation procedures and monitor interventions previously put in place following the Recertification Survey of 05/17/18. This was for one deficiency that was originally cited at the regulatory grouping of 483.21 in May of 2017 and subsequently recited on the current Recertification Survey of 05/23/19. The repeated deficiency was in the area of Developing/Implementing Comprehensive Care Plans. The facility ' s continued failure during the recent survey showed a pattern of the facility ' s inability to sustain an effective QAA program. Findings included:	F 867	1. An action plan will be developed to address the care plan issue for obtaining weekly weights. Care plan implementation will be added to the monthly QA agenda. 2. Residents with physician orders for weekly weights have the potential to be affected by the same deficient practice. QA Committee will meet monthly and PRN to address care issues identified through record review and audits. 3. Newly identified concerns with care plan implementation identified during the audits will be reported to the facility's QA committee for review, analysis, and recommendation monthly and PRN.	6/19/19	

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F 867	<p>Continued From page 25</p> <p>This citation is cross referenced to F656 (483.21). Based on observations, record review, and staff interviews, the facility failed to implement an intervention in the current care plan to obtain weekly weights for 4 weeks for 1 of 3 residents (Resident #218) observed for weight loss.</p> <p>The facility was cited during the 05/17/18 survey at 483.21 for failure to implement a plan of care for psychotropic medications for 1 of 5 residents reviewed. During the current recertification survey the facility failed to implement an intervention to obtain weekly weights for 1 of 3 residents reviewed.</p> <p>An interview was conducted with the Administrator on 05/23/19 at 2:30 PM. The Administrator reported that implementing care plans was no longer in QAA and she thought the problem had been resolved. The Administrator reported as a result of the deficiency, Developing and Implementing Care Plans will be part of QAA.</p>	F 867	<p>4. Administrator or designee will monitor QA Committee meetings, completion of recommended audits/monitoring, and QA recommendations monthly or until consistent compliance is identified.</p>	