

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/20/2019
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS NSG & REH JOHN			STREET ADDRESS, CITY, STATE, ZIP CODE 2315 HIGHWAY 242 NORTH BENSON, NC 27504	
(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 The survey team entered the facility on 5/16/19 to conduct a complaint survey and exited on 5/18/19. Additional information was obtained on 5/20/19. Therefore, the exit date was changed to 5/20/19.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to provide assistance with incontinent care for five (Residents # 12, #13, #14, #15, and # 16) of eight residents for whom incontinent care was observed. The findings included: 1. Resident # 12 was admitted to the facility on 12/30/17 with a diagnosis of stroke. Review of the resident's quarterly MDS (Minimum Data Set) assessment, dated 5/9/19, revealed the resident was cognitively intact and needed total assistance for toileting. The resident needed extensive assistance for hygiene, and was assessed to always be incontinent of both bladder and bowel. The resident's care plan, last revised on 5/15/19, revealed staff were directed to "provide incontinence care as needed." Resident # 12 was observed on 5/18/19 at 9:55	F 677	This Plan of Correction is the Center's credible allegation of compliance. Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The Center respectfully requests a desk review for this Plan of Correction. Residents #12, #13, #14, #15, #16 received incontinent care on 5/18/19. Residents #12, #13, #14, #15, #16 were assessed with no negative outcome. A 100% audit related to incontinent care was completed on current residents to ensure there are no additional residents affected by this practice. The audit was completed by the Administrator and Nurse	6/17/19

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 677	<p>Continued From page 1</p> <p>AM as NA # 1 began to check the resident for incontinence needs. As NA # 1 was preparing for care, Resident # 12 stated she had been wet since 7:00 AM. Resident # 12 further reported the facility did not have enough help, and no one had been into her room to check on her that morning since 7:00 AM for incontinence needs. The resident stated she waited and did not call because she thought someone would automatically come and check her brief. Resident # 12 stated about 10 minutes ago she had a stool in her brief in addition to being wet. Resident # 12 stated she called at that time. Resident # 12 was observed to have a disposable brief that was saturated with dark urine. The urine had gone through to the incontinent pad beneath the resident's brief. The resident also had a stool, and there was a foul odor.</p> <p>NA # 1 was interviewed directly following completion of the 9:55 AM care on 5/18/19. The interview revealed Resident # 12 had not been checked from 7:00 AM to 9:55 AM for incontinence needs. NA # 1 stated when she first arrived to work at 7:00 AM, Resident # 12 had not been assigned to her. Resident # 12 had initially been assigned to another nurse aide, who had not shown up for work that morning. NA # 1 stated around 8:30 AM she had been told that Resident # 12 had been assigned to her, but she (NA # 1) was feeding residents at that time and stayed busy with feeding tasks until around 9:30 AM. NA # 1 stated 9:55 AM was the first opportunity she had to check the resident for incontinence needs.</p> <p>Interview with the hall nurse on 5/18/19 at 11:00 AM and again on 5/18/19 at 12:50 PM revealed she did not usually work on the unit. The nurse</p>	F 677	<p>Management on 5/18/19 and any areas of concern were addressed immediately.</p> <p>Nursing staff re-educated by the Staff Development Coordinator/Designee on providing incontinent care. The education will be completed by 6/17/19 by the Staff Development Coordinator/Designee.</p> <p>Current residents with a BIMS greater than 13 will be interviewed regarding ADL care, specifically incontinent care. Non-interviewable residents will be observed for evidence that ADL needs have been met, specifically incontinent care. Ten residents per week will be interviewed or observed for ADL care specifically incontinent care for twelve weeks and discussed in the morning Stand Up Meeting. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by the Administrator/Designee. Any trends will be noted and immediate correction implemented.</p> <p>All shifts to include weekends, holidays, and 'off hour' time will be assigned to a Lead Nurse who will validate all staff have arrived that are scheduled for their assigned shift. The assignment sheets will indicate who is designated as the lead nurse and who is designated as the on call nurse.</p> <p>Staff members assigned to direct patient care will not exit their shift until appropriate direct care relief arrives, and this will be validated by the assigned lead</p>		

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F 677	<p>Continued From page 2</p> <p>stated someone else did staffing, and she had not been aware at 11:00 AM that a NA had not shown up for work at 7:00 AM.</p> <p>Interview with the DON (Director of Nursing) on 5/18/19 at 1:15 PM revealed that a nurse aide (Nurse Aide # 3) had not shown up for work at 7:00 AM as scheduled. NA # 3 was supposed to have been assigned to Resident # 12. The DON stated the night shift NA, who had worked from 11:00 PM on 5/17/19 to 7:00 AM on 5/18/19, should not have gone home at 7:00 AM when NA # 3 did not come to work, but the night shift NA had left work. The DON stated she first became aware on 5/18/19 at 11:30 AM that NA # 3 had not been replaced by another staff member. The DON confirmed there had not been anyone designated to care for Resident # 12 prior to NA # 1, and it was her expectation that the resident would have been checked for incontinence needs and care rendered prior to 9:55 AM on the dayshift of 5/18/19.</p> <p>2. Record review revealed Resident # 13 was admitted to facility on 11/7/18 with stroke, aphasia, and hemiplegia/hemiparesis.</p> <p>Review of Resident # 13's quarterly MDS (Minimum Data Set) assessment, dated 2/14/19, revealed the resident was cognitively impaired, needed extensive assistance with hygiene, total assistance with toileting, and was incontinent of bowel and bladder all the time.</p> <p>Resident # 13's care plan, last revised on 5/14/19, directed staff to provide incontinent care as needed.</p> <p>Resident # 13 was observed on 5/18/19 at 10:10</p>	F 677	<p>nurse for all shifts, 24 hours/7 days a week. The lead nurse will be indicated on the assignment sheets daily for each shift. The scheduler will have ownership to ensure a lead nurse and on call nurse are designated each shift. The DON or the Administrator in the DON's absence will ensure each daily staffing assignment indicates the lead nurse and on call nurse with contact information.</p> <p>The assigned lead nurse will notify the designated "on call" nurse should a direct care staff member not arrive to their scheduled shift. The lead nurse and the assigned on call nurse will assist with obtaining appropriate direct care staff to report to work and relieve the direct care worker.</p> <p>The assigned lead nurse will notify the DON or the Administrator, in the DON's absence of the staffing concern immediately for assistance to ensure proper staffing model and assignment.</p> <p>This practice will be initiated immediately and ongoing.</p>		

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F 677	<p>Continued From page 3</p> <p>AM as Nurse Aide (NA) # 1 provided incontinent care. The resident's brief was observed saturated with urine, and there was a strong, foul odor of urine. As NA # 1 removed the brief and moved the brief towards the trash can for disposal, it was observed that the brief visibly sagged with the weight of urine in it.</p> <p>Interview with NA # 1 directly following the 10:10 AM care, revealed when she first arrived to work at 7:00 AM, Resident # 13 had not been assigned to her, but rather to another nurse aide, who had not shown up for work that morning. NA # 1 stated around 8:30 AM she had been told that Resident # 13 had been assigned to her, but she (NA # 1) was feeding residents at that time and stayed busy with feeding tasks until around 9:30 AM. NA # 1 stated 10:10 AM was the first opportunity she had to check Resident # 13 for incontinence needs, and there had not been anyone assigned to Resident # 13's care between 7:00 AM and 8:30 AM.</p> <p>Interview with the hall nurse on 5/18/19 at 11:00 AM and again on 5/18/19 at 12:50 PM revealed she did not usually work on the unit. The nurse stated someone else did staffing, and she had not been aware at 11:00 AM that a NA had not shown up for work at 7:00 AM.</p> <p>Interview with the DON (Director of Nursing) on 5/18/19 at 1:15 PM revealed that a nurse aide (Nurse Aide # 3) had not shown up for work at 7:00 AM as scheduled. NA # 3 was supposed to have been assigned to Resident # 13. The DON stated the night shift NA, who had worked from 11:00 PM on 5/17/19 to 7:00 AM on 5/18/19, should not have gone home at 7:00 AM when NA # 3 did not come to work, but the night shift NA</p>	F 677			

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F 677	<p>Continued From page 4</p> <p>had left work. The DON stated she first became aware on 5/18/19 at 11:30 AM that NA # 3 had not been replaced by another staff member. The DON confirmed there had not been anyone designated to care for Resident # 13 prior to NA # 1, and it was her expectation that the resident would have been checked for incontinence needs and care rendered prior to 10:10 AM on the dayshift of 5/18/19.</p> <p>3. Resident # 14 was last admitted to the facility on 1/19/19. The physician noted on a progress note, dated 4/24/19, that the resident had "significant dementia."</p> <p>Review of Resident # 14's annual MDS (Minimum Data Set) assessment, dated 4/26/19, revealed the resident needed extensive assistance with her toileting and hygiene needs. The resident was assessed to be frequently incontinent of urine.</p> <p>Resident # 14's care plan, last reviewed on 5/14/19, directed staff to "provide incontinence care as needed."</p> <p>Resident # 14 was observed on 5/18/19 at 10:25 AM as NA # 1 checked the resident for incontinence needs. The resident's brief was observed saturated with urine, and there was a strong, foul odor of urine. As NA # 1 removed the brief and moved the brief towards the trash can for disposal, it was observed that the brief visibly sagged with the weight of urine in it. The front of the resident's gown was also observed wet with urine. The resident could not state how long she had been wet.</p> <p>Interview with NA # 1 directly following the 10:25 AM care and again on 5/18/19 at 2:50 PM</p>	F 677			

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F 677	<p>Continued From page 5</p> <p>revealed she had checked on Resident # 14 around 7:10 AM. The resident was very sleepy at that time, and had requested that NA # 1 come back. According to NA # 1, breakfast trays arrived around 8:00 to 8:10 AM, and she was busy feeding residents from that time until 9:30 AM. At 8:30 AM she had been informed that she was assigned additional residents because another NA had not shown up for work that AM at 7:00 AM. NA # 1 went to care for the additional residents when she finished feeding residents at 9:30 AM. Therefore, 10:25 AM was the first opportunity she had to get back to check Resident # 14 for incontinence needs following 7:10 AM that morning.</p> <p>Interview with the Director of Nursing (DON) on 5/18/19 at 3:10 PM revealed it was her expectation that NA # 1 would have gotten back to check on Resident # 14 before 10:25 AM following the resident's request at 7:10 AM. According to the DON, she had not been aware until 11:30 AM on 5/18/19 that there had not been a replacement for the nurse aide who had not reported to work, and that NA # 1 was having to care for additional residents than the ones initially assigned to her.</p> <p>4. Record review revealed Resident # 15 was admitted to the facility on 4/29/17 with a diagnosis of vascular dementia. Review of the residents annual MDS (Minimum Data Set) assessment, dated 2/1/19 revealed the resident was severely cognitively impaired, needed total assistance with toileting, extensive assistance with hygiene, and was always incontinent. The resident's care plan, last revised on 5/3/19, directed staff to "provide incontinence care as needed."</p>	F 677			

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F 677	<p>Continued From page 6</p> <p>Resident # 15 and Resident # 16 resided in the same room.</p> <p>Record review revealed Resident # 16 was admitted to the facility on 3/26/18 and had a history of stroke. Review of Resident # 16's annual MDS assessment, dated 4/3/19, revealed the resident had a BIMs (Brief Interview for Mental Status) of 15 (indicating she was cognitively intact). The resident was assessed to need extensive assistance with toileting and hygiene needs, and being frequently incontinent of bowel and bladder.</p> <p>On 5/18/19 at 10:40 AM NA # 2 was accompanied as she entered the room of Resident # 15 and Resident # 16. The call light was on at the time of room entry.</p> <p>Resident # 16 reported the following. She had called several times for help, and had been wet since 8:30 AM. At some point between 8:30 AM and 10:40 AM, she had also had a bowel movement, and she was currently soiled with both. Someone had answered her call bell at one point and said they would have to check and see who was assigned to her, but did not offer care, and her call light was turned off. Another time she called for assistance and was told that someone would be back, and no one came. This was the third time she had put her call light on that morning. Resident 16 stated there was not enough staff and "this happened too much-especially on the week-end." Resident # 16 was observed to request that NA # 2 please care for her roommate (Resident # 15) first, because she was aware Resident # 15 was confused and could not call to be checked. Resident # 16 stated no one had been in the room to check Resident #</p>	F 677			

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F 677	<p>Continued From page 7</p> <p>15 (her roommate) for incontinence needs since night shift made their incontinence check at 5:00 AM on 5/18/19, and she was worried about her.</p> <p>NA # 2 was observed to first care for Resident # 15. Resident # 15's brief was saturated and the incontinent pad below the brief was wet also. There was a foul odor of urine.</p> <p>NA # 2 was observed to care for Resident # 16 directly following completion of Resident # 15's care. Resident # 16 was observed to have a saturated brief and also be soiled with stool. The resident's bottom was slightly red where she had been laying against the urine and stool.</p> <p>NA # 2 was interviewed on 5/18/19 at 11:08 AM and reported the following. NA # 2 confirmed that she was aware that Resident # 16 was wet sometime between 8:55 AM and 9:15 AM. NA # 2 stated she had been in the room feeding Resident # 15 at the time, and Resident # 16 told her she (Resident # 16) was wet with urine. NA # 2 stated she told Resident # 16 that they would get to her as soon as possible. NA # 2 stated a NA had not shown up for work, and Resident # 15 and #16 were supposed to have been on the assignment of the NA, who had not come to work. NA # 2 stated she had to finish feeding residents when she was told by Resident # 16 that she was wet. Following the completion of breakfast, she had to attend to another resident that required a total bed change due to diarrhea. NA # 2 stated 10:40 AM was the first opportunity she had to check on Resident # 15 and Resident # 16.</p> <p>Interview with the hall nurse on 5/18/19 at 11:00 AM and again on 5/18/19 at 12:50 PM revealed</p>	F 677			

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F 677	Continued From page 8 she did not usually work on the unit. The nurse stated someone else did staffing, and she had not been aware at 11:00 AM that a NA had not shown up for work at 7:00 AM. Interview with the DON (Director of Nursing) on 5/18/19 at 1:15 PM revealed that a nurse aide (Nurse Aide # 3) had not shown up for work at 7:00 AM as scheduled. NA # 3 was supposed to have been assigned to Residents # 15 and # 16. The DON stated the night shift NA, who had worked from 11:00 PM on 5/17/19 to 7:00 AM on 5/18/19, should not have gone home at 7:00 AM when NA # 3 did not come to work, but the night shift NA had left work. The DON stated she first became aware on 5/18/19 at 11:30 AM that NA # 3 had not been replaced by another staff member. The DON confirmed there had not been anyone designated to care for Resident # 15 and #16 prior to NA # 2 providing incontinent care, and it was her expectation that both residents would have been checked for incontinence needs and care rendered prior to 10:40 AM on the dayshift of 5/18/19.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: For two of five resident (resident #5 and #4) the	F 689	Resident #4 now receives weights via	6/17/19	

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F 689	<p>Continued From page 9</p> <p>facility failed to provide the correct lift to transfer a resident that was unable to weight bear causing the resident to slip out of the lift (resident #5). Further the facility failed to have a wheelchair scale that staff could push a wheelchair onto without going across a threshold which caught a wheelchair wheels causing a resident to be thrown forward out of the wheelchair, which resulted in bruising on a resident's face. (resident 4).</p> <p>1. Resident #5 was admitted to the facility on 11/29/18 with diagnosis of post Back fusion, Spinal stenosis lumbar region, Morbid obesity, Lumbago with sciatica and muscle weakness.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 3/16/19 revealed that Resident #5 was cognitively intact and required extensive assistance of 2 for bed mobility, transfers and dressing and total dependence of 2 for toileting and personal hygiene. Resident #5 was also always incontinent of bowel and bladder.</p> <p>A review of Resident #5's care plan dated March 2019 revealed focus areas which included risk for falls r/t recent surgery, weakness, altered mental status, side effects of psychoactive drugs and antihypertensives contributing to gait disturbance, balance disturbance, syncope, movement disorders. Her goal was falls risk will be reduced by the next review date. Interventions included to: Anticipate and meet my needs as much as possible, encourage me to stand up slowly, encourage me to use my walker when ambulating, observe for possible side effects from medications that may affect balance and gait and report to nurse if I have change in gait or balance and Physical Therapy (PT) to evaluate and treat</p>	F 689	<p>mechanical lift. Resident #5 is transferred via total lift.</p> <p>A 100% audit related to transfer status was completed on current residents to ensure there are no additional residents affected by this practice. The audit will be completed by the Director of Nursing by 6/7/19 and any areas of concern addressed immediately. A new scale was received by the facility on 6/6/19.</p> <p>Nursing staff re-educated by Staff Development Coordinator/Designee regarding appropriate use of wheel chair scales. Nursing staff re-educated by Staff Development Coordinator/Designee regarding appropriate transfer status.</p> <p>Current residents will be observed being weighed. Five residents per week will be observed by the Director of Nursing/Designee for correct wheelchair positioning on the scales for twelve weeks and discussed in the morning Stand Up Meeting. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by the Administrator/Designee. Any trends will be noted and immediate correction implemented. Current residents will be observed for appropriate transfer status. Five residents per week will be observed by the Director of Nursing/Designee during transfer to ensure correct mode of transfer reflected on the resident's plan of care. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by</p>		

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F 689	<p>Continued From page 10 as ordered or as needed.</p> <p>Review of the PT evaluation dated 11/30/18 revealed Resident #5 was 100% dependent for sit to stand transfers. In section GG of this evaluation, mobility for sit to stand indicated Resident #5 was " dependent: Helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity ". Strength in left and right lower extremities was coded and 0 out of 5.</p> <p>A record review of a rehabilitation progress note dated 12/19/18 revealed " She (Resident #5) has no lower strength at all. She is now essentially paralyzed from waist down, confirmed 0/5 strength in office notes 11/14/18 and PT evaluations prior. "</p> <p>A review of the manual for the Sara 3000 Sit to Stand lift revealed "Warning: Before attempting to use Sara 3000, a full clinical assessment of the resident his/her condition, and suitability must be carried out by a qualified person. "The manual further stated that prior to using, individuals must be able to bear weight on at least one leg.</p> <p>During an interview with the resident on 5/16/19 4:30 pm, Resident #5 stated that in December 2018, the aide placed her in a sit to stand lift for a transfer. This was her 2nd time being in the sit to stand lift. Once in the lift, she began to slip down and yelled out to the aide who was across the room gathering supplies. Before the aide could reach her, she fell on the floor. After nurse aide (NA) #3, called for assistance, Resident #5 was placed on a pad and raised back in her bed by a mechanical lift with the assistance of NA #4.</p>	F 689	<p>the Administrator/Designee. Any trends will be noted and immediate correction implemented</p>		

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F 689	<p>Continued From page 11</p> <p>During an interview with NA #3 on 05/17/19 at 11:28 am she stated she had worked with Resident #5, who was a total care resident and usually required 2 people. NA #3 stated that the resident was unable to stand or use her lower extremities. NA #3 confirmed that around December 2018, NA #3 and NA #4 attempted to use the sit to stand lift with the resident. NA #3 stated that after Resident #5 had been positioned on the sit to stand, she started slipping down. When NA #3 and NA #4, recognized it, they pushed the lift back to the bed and eased Resident #5 back on the bed. NA #3 stated that Resident #5 did not land on the floor and she did not report this incident to anyone. NA #3 stated that prior to this day, she had used the mechanical lift but this day she tried to use the sit to stand with the help of a co-worker. After this attempt failed, the resident was lifted into the chair via mechanical lift.</p> <p>Interview with administrative staff on 05/17/19 revealed NA # 4 was not available for interview.</p> <p>During a follow up interview with Resident # 5 on 05/17/19 at 10:45, Resident # 5 was consistent in her statement that she had been placed in the sit to stand lift at a time when she could not bear weight on her legs and ended up on the floor after slipping.</p> <p>Interview with the Physical therapist (PT) #1 on 5/17/19 at 3:40pm, revealed that upon admission, a physical therapy evaluation was performed. It was confirmed with the Physical Therapist that Resident # 5 had no strength in her legs when the PT assessed her on 11/30/18 and was totally dependent on staff for transfers.</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>A representative for the company, which manufactures the facility's sit to stand mechanical lift was interviewed on 5/20/19 at 8:50 AM. According to the company representative, a resident who is unable to bear any weight on their legs should never be placed in a sit to stand lift due to safety concerns. The representative stated a resident must be able to bear weight on at least one leg and have some upper body strength in order to use the sit to stand lift.</p> <p>The Director of Nursing (DON) was interviewed on 05/16/19 at 1:45 pm. The DON stated she spoke with Resident #5 who mentioned a fall involving a lift, but she did not investigate as she believed it to be a fall that occurred prior to admission and at another facility. The DON confirmed that she was aware of an incomplete transfer using the sit to stand lift for Resident # 5, but was unable to provide any evidence that she had investigated how the nurse aides decided to place the resident in the sit to stand lift given she could not bear weight, and what happened during the transfer when the resident began slipping from the lift. According to the DON there was no formal process to evaluate residents for the type of the lift used. The DON stated the nurses or nurse aides decided</p> <p>2. Resident #4 was admitted to the facility on 09/17/19. Her diagnoses included End stage renal disease, Hypertension, Diabetes Mellitus and Atrial Fibrillation.</p> <p>A review of a quarterly Minimum Data Set (MDS) dated 01/10/19 revealed that Resident #4 was cognitively intact and required extensive assistance of 1 person with personal care and</p>	F 689			

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F 689	<p>Continued From page 13</p> <p>activities of daily living (ADLS). Resident #4 ' s gait was unsteady and moving from seated to stand position was unsteady, requiring assistance of 1 person.</p> <p>Review of her care plan dated 5/7/19 revealed a focus on falls r/t weakness, psychotropic medication. Her goal included minimizing falls through current interventions/ Interventions included: Anticipate and meet my needs as much as possible, encourage me to participate in activities that promote exercise, use of reacher for grasping objects, physical activity for strengthening and improved mobility and observe for possible side effects from medications that may affect balance and gait.</p> <p>Another focus area was self-care deficit with a goal to maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the next 90 days. Interventions included staff assistance with transfers and bathing; offering choices and encouragement of the use of call light for assistance.</p> <p>Review of Resident #4's medication record for January 2019 included Xarelto (blood thinner) used to treat her Atrial Fibrillation.</p> <p>At 06:05 am during an interview, NA #5 stated that around 5 am on 01/18/19, she transferred the resident in her wheelchair (w/c) to the w/c scale to obtain her daily weight. She pushed the w/c forward toward the incline on the scale but was unable to get the wheels over the threshold on the scale. Then, with the resident seated on the edge of the chair, she pulled the w/c back and with a greater force, pushed the w/c forward pass</p>	F 689			

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F 689	<p>Continued From page 14</p> <p>the threshold. This time the wheel on the w/c got stuck and the resident was pitched forward and ended up face down on the floor. She ran to get the assistance of Nurse #4. Resident #4 had quickly formed a large hematoma to her forehead and sustained significant facial bruising. Nurse #4 notified Resident #4 's responsible party (RP) and physician. Resident #4 was sent to Wake Med Emergency Room. CT scan of her head was negative, and Resident #4 returned to the facility. The hematoma along with the significant facial bruising cleared after about two weeks.</p> <p>An interview with Resident #4 was conducted on 05/17/19. Resident #4 stated that she received daily weights, sometimes she refuses them. She states she is an early riser and like to be up in her chair early in the morning. Resident #4 recounted the story as given by NA #5. She stated that she felt the aide dumped her out of the wheelchair onto the floor but that the aide did not mean to do it, she was just careless.</p> <p>During an interview with the Director of Nursing (DON) on 05/16/19 at 1:45 pm, the DON stated weights are generally done by the aides on first and third shifts. The DON stated that the incident was investigated and reviewed by the Interdisciplinary team (IDT) and determined that the incline of scale entrance with resident leaning forward appeared to be contributing factors. The DON met with the RP to review the findings. As a result, the wheelchair scale was relocated and repositioned to change the entrance of the scale and RP requested the resident to have all weights obtained via mechanical lift. The DON was unable to provide any evidence of staff education related to this incident.</p>	F 689			

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F 689	Continued From page 15 Interview with NA #3 on 05/17/19 at 10:30 am stated that the scale has been an ongoing problem. The weight of the resident and the w/c makes it difficult to get over the " bump " on the scale. On 05/17/19 at 11:10 am, NA #2 stated that when placing a resident on the w/c scale, you have to nearly lift the resident and the wheelchair up over the " bump " or get another aide to assist you. It is easy to dump a resident out if you are not careful. On 05/19/18, during the investigation, the scale was replaced with a new one. The During an interview at 9:17 AM on 05/20/19, the DON stated that after role playing the incident it was felt to be related to the scale's incline and the resident leaning forward. For this resident, we are no longer using the wheelchair scale.	F 689			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		6/17/19	

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F 725	<p>Continued From page 16</p> <p>nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, when a Nurse Aide failed to report to work, the facility failed to allocate staff to assure there was sufficient staff to meet the incontinent needs of five (Resident # 12, # 13, # 14, # 15, and # 16) of eight residents reviewed for incontinence needs. The findings included:</p> <p>Resident # 12 was admitted to the facility on 12/30/17 with a diagnosis of stroke.</p> <p>Review of the resident's quarterly MDS (Minimum Data Set) assessment, dated 5/9/19, revealed the resident was cognitively intact and needed total assistance for toileting. The resident was assessed to always be incontinent of both bladder and bowel.</p> <p>Resident # 12 was observed on 5/18/19 at 9:55 AM as NA # 1 began to check the resident for incontinence needs. As NA # 1 was preparing for care, Resident # 12 stated she had been wet since 7:00 AM. Resident # 12 further reported the facility did not have enough help, and no one had been into her room to check on her that morning</p>	F 725	<p>Residents #12, #13, #14, #15, #16 received incontinent care on 5/18/19. Residents #12, #13, #15, #15, #16 were assessed with no negative outcome. Staff assignments were corrected to reflect complete resident coverage on 5/18/19.</p> <p>100% review of staffing ratios and assignments were completed on 5/24/19 by the Director of Nursing and Nurse Management. Review revealed sufficient staffing for the facility based on ratios and acuity.</p> <p>Nursing staff On-Call re-educated by the Director of Nursing/Designee on 6/7/19 to include importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. Administrator and Director of Nursing will review daily staffing sheets at the morning Stand Up Meeting to ensure staff is scheduled to meet the ADL needs of the residents.</p>		

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F 725	<p>Continued From page 17</p> <p>since 7:00 AM for incontinence needs. The resident stated she waited and did not call because she thought someone would automatically come and check her brief. Resident # 12 stated about 10 minutes ago she had stool in her brief in addition to being wet. Resident # 12 stated she called at that time. Resident # 12 was observed to have a disposable brief that was saturated with dark urine. The urine had gone through to the incontinent pad beneath the resident's brief. The resident also had a stool, and there was a foul odor.</p> <p>NA # 1 was interviewed directly following completion of care that started at 9:55 AM on 5/18/19. The interview revealed Resident # 12 had not been checked from 7:00 AM to 9:55 AM for incontinence needs. NA # 1 stated when she first arrived to work at 7:00 AM, Resident # 12 had not been assigned to her. Resident # 12 had initially been assigned to another nurse aide, who had not shown up for work that morning. NA # 1 stated around 8:30 AM she had been told that Resident # 12 had been assigned to her, but she (NA # 1) was feeding residents at that time and stayed busy with feeding tasks until around 9:30 AM. NA # 1 stated 9:55 AM was the first opportunity she had to check the resident for incontinence needs.</p> <p>Record review revealed Resident # 13 was admitted to facility on 11/7/18 with stoke aphasia, and hemiplegia/hemiparesis.</p> <p>Review of Resident # 13's quarterly MDS (Minimum Data Set) assessment, dated 2/14/19, revealed the resident was cognitively impaired, needed extensive assistance with hygiene, total assistance with toileting, and was incontinent of</p>	F 725	<p>Current residents with a BIMS greater than 13 will be interviewed regarding ADL care, specifically incontinent care. Non-interviewable residents will be observed for evidence that ADL needs have been met. Ten residents per week will be interviewed or observed for ADL care, specifically incontinent care for twelve weeks and discussed in the morning Stand Up Meeting. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by the Administrator/Designee. Any trends will be noted and immediate correction implemented. Ten residents per week will be interviewed regarding staffing and incontinent care for twelve weeks and discussed in the morning Stand Up Meetings. Results of the audits will be reviewed at the monthly Quality Assurance Meeting for three months by the Administrator/Designee. Any trends will be notes and immediate correction implemented.</p> <p>All shifts to include weekends, holidays, and 'off hour' time will be assigned to a Lead Nurse who will validate all staff have arrived that are scheduled for their assigned shift. The assignment sheets will indicate who is designated as the lead nurse and who is designated as the on call nurse.</p> <p>Staff members assigned to direct patient care will not exit their shift until appropriate direct care relief arrives, and this will be validated by the assigned lead</p>		

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F 725	<p>Continued From page 18 bowel and bladder all the time.</p> <p>Resident # 13 was observed on 5/18/19 at 10:10 AM as Nurse Aide (NA) # 1 provided incontinence care. The resident's brief was saturated with urine, and there was a strong, foul odor of urine. As NA # 1 removed the brief and moved the brief towards the trash can for disposal, it was observed that the brief visibly sagged with the weight of urine in it.</p> <p>Interview with NA # 1 directly following the completion of 10:10 AM care on 5/18/19, revealed Resident # 13 was added to her assignment at 8:30 AM, and 10:10 AM on 5/18/19 was the first opportunity she had to check Resident # 13 for incontinence needs. The NA stated there had not been anyone assigned to Resident # 13's care between 7:00 AM and 8:30 AM because a NA had not shown up for duty, and she (NA # 1) was busy feeding residents until 9:30 AM.</p> <p>Resident # 14 was last admitted to the facility on 1/19/19. The physician noted on a progress note, dated 4/24/19, that the resident had "significant dementia."</p> <p>Review of Resident # 14's annual MDS (Minimum Data Set) assessment, dated 4/26/19, revealed the resident needed extensive assistance with her toileting and hygiene needs. The resident was assessed to be frequently incontinent of urine.</p> <p>Resident # 14 was observed on 5/18/19 at 10:25 AM as NA # 1 checked the resident for incontinence needs. The resident's brief was observed saturated with urine, and there was a strong, foul odor of urine. As NA # 1 removed the</p>	F 725	<p>nurse for all shifts, 24 hours/7 days a week. The lead nurse will be indicated on the assignment sheets daily for each shift. The scheduler will have ownership to ensure a lead nurse and on call nurse are designated each shift. The DON or the Administrator in the DON's absence will ensure each daily staffing assignment indicates the lead nurse and on call nurse with contact information.</p> <p>The assigned lead nurse will notify the designated "on call" nurse should a direct care staff member not arrive to their scheduled shift. The lead nurse and the assigned on call nurse will assist with obtaining appropriate direct care staff to report to work and relieve the direct care worker.</p> <p>The assigned lead nurse will notify the DON or the Administrator, in the DON's absence of the staffing concern immediately for assistance to ensure proper staffing model and assignment.</p> <p>This practice will be initiated immediately and ongoing.</p>		

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F 725	<p>Continued From page 19</p> <p>brief and moved the brief towards the trash can for disposal, it was observed that the brief visibly sagged with the weight of urine in it. The front of the resident's gown was also observed wet with urine. The resident could not state how long she had been wet.</p> <p>Interview with NA # 1 directly following the completion of care at 10:25 AM and again on 5/18/19 at 2:50 PM revealed she had checked on Resident # 14 around 7:10 AM. The resident was very sleepy at 7:10 AM, and had requested that NA # 1 come back. According to NA # 1, breakfast trays arrived around 8:00 to 8:10 AM, and she was busy feeding residents from that time until 9:30 AM. At 8:30 AM she had been informed that she was assigned additional residents because another NA had not shown up for work that AM. NA # 1 went to care for the additional residents when she finished feeding residents at 9:30 AM. Therefore, NA # 1 stated 10:25 AM was the first opportunity she had to get back to check Resident # 14 for incontinence needs following 7:10 AM that morning.</p> <p>Record review revealed Resident # 15 was admitted to the facility on 4/29/17 with a diagnosis of vascular dementia. Review of the resident's annual MDS (Minimum Data Set) assessment, dated 2/1/19 revealed the resident was severely cognitively impaired, needed total assistance with toileting, extensive assistance with hygiene, and was always incontinent.</p> <p>Resident # 15 and Resident # 16 resided in the same room.</p> <p>Record review revealed Resident # 16 was admitted to the facility on 3/26/18 and had a</p>	F 725			

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F 725	<p>Continued From page 20</p> <p>history of stroke. Review of Resident # 16's annual Minimum Data Set (MDS) assessment, dated 4/3/19, revealed the resident had a BIMS of 15 (indicating she was cognitively intact). The resident was assessed to need extensive assistance with toileting and hygiene needs, and being frequently incontinent of bowel and bladder.</p> <p>On 5/18/19 at 10:40 AM, NA # 2 entered the room of Resident # 15 and Resident # 16. The call light was on at the time of room entry.</p> <p>Resident # 16 reported the following. She had called several times for help, and had been wet since 8:30 AM. At some point between 8:30 AM and 10:40 AM, she also had a bowel movement, and she was currently soiled with both and had never received care since 8:30 AM. Someone had answered her call bell at one point and said they would have to check and see who was assigned to her, but did not offer care, and her call light was turned off. Another time she called for assistance and was told that someone would be back, and no one came. This was the third time she had put her call light on that morning. Resident 16 stated there was not enough staff and "this happened too much-especially on the week-end." Resident # 16 was observed to request that NA # 2 care for her roommate (Resident # 15) first, because she was aware Resident # 15 was confused and could not call to be checked. Resident # 16 stated no one had been in the room to check Resident # 15 (her roommate) for incontinence needs since night shift made their incontinence check at 5:00 AM on 5/18/19, and she was worried about her.</p> <p>NA # 2 was observed to first care for Resident # 15. Resident # 15's brief was saturated and the</p>	F 725			

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F 725	<p>Continued From page 21</p> <p>incontinent pad below the brief was wet also. There was a foul odor of urine.</p> <p>NA # 2 was observed to care for Resident # 16 directly following completion of Resident # 15's care. Resident # 16 was observed to have a saturated brief and also be soiled with stool. The resident's bottom was slightly red where she had been laying against the urine and stool.</p> <p>NA # 2 was interviewed on 5/18/19 at 11:08 AM and reported the following. NA # 2 confirmed that she was aware that Resident # 16 was wet sometime between 8:55 AM and 9:15 AM. NA # 2 stated she had been in the room feeding Resident # 15 at the time, and Resident # 16 told her she (Resident # 16) was wet with urine. NA # 2 stated she told Resident # 16 that they would get to her as soon as possible. NA # 2 stated a NA had not shown up for work, and Resident # 15 and #16 were supposed to have been on the assignment of the NA, who had not come to work. NA # 2 stated she had to finish feeding residents when she was told by Resident # 16 that she was wet. Following the completion of breakfast, she had to attend to another resident that required a total bed change due to diarrhea. NA # 2 stated 10:40 AM was the first opportunity she had to check on Resident # 15 and Resident # 16 for their incontinence needs.</p> <p>Interview with the hall nurse on 5/18/19 at 11:00 AM and again on 5/18/19 at 12:50 PM revealed she did not usually work on the unit. The nurse stated someone else did staffing, and she had not been aware at 11:00 AM that a NA had not shown up for work at 7:00 AM.</p> <p>Nurse # 3 was interviewed on 5/18/19 at 3:35 PM.</p>	F 725			

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F 725	<p>Continued From page 22</p> <p>Nurse # 3 stated she was the on call nurse from Friday evening on 5/17/19 through Saturday 5/18/19. As the on call nurse, Nurse # 3 stated she handled staffing. Nurse # 3 reported the following. When she left work on Friday afternoon (5/17/19), NA # 3 was scheduled to work on Saturday from 7:00 AM to 3:00 PM. With NA # 3 on the schedule, Nurse # 3 was aware there was still one NA staffing need for day shift on Saturday 5/18/19 that had not been filled for the entire facility. She called before night shift staff left at 7:00 AM on 5/18/19, and arranged for a night shift NA to stay over and cover for the dayshift staffing need that had not been filled. At that point, Nurse # 3 then thought the staffing was covered for the entire facility. On 5/18/19 sometime between 7:00 AM and 7:30 AM, a nurse aide had contacted her and let her know that NA # 3 had not shown up for work. This again left the 7:00 AM to 3:00 PM shift short one nurse aide for 5/18/19. Nurse # 3 stated she informed the NA, who had called her, she would try to get in touch with NA # 3, and that the staff would need to go to a "split assignment," and take on more residents to cover for NA # 3. Nurse # 3 stated NA # 3 was an agency nurse aide, and she called and left the agency a message that their scheduled NA had not reported to work.</p> <p>Interview with the DON (Director of Nursing) on 5/18/19 at 1:15 PM revealed that a nurse aide (Nurse Aide # 3) had not shown up for work at 7:00 AM as scheduled. NA # 3 was supposed to have been assigned to Residents # 12, #13, # 15 and # 16. The DON stated the night shift NA, who had worked from 11:00 PM on 5/17/19 to 7:00 AM on 5/18/19 and cared for Resident # 12, # 13, # 15, and # 16, should not have gone home at 7:00 AM. She should have worked in place of NA # 3.</p>	F 725			

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F 725	Continued From page 23 The DON stated a designated on call staff member carried a phone with them at all times to take care of staffing issues. The DON stated a nurse was to alert the on call staff member if they see that there was someone who did not show up for work, and someone from the previous shift is to stay over until the position is covered. The DON stated she had been aware that NA # 3 had not reported to work, but she had been informed by the on call nurse, who handled staffing, that a night shift NA had stayed over for dayshift on 5/18/19. The DON stated she assumed the night shift staff member, who stayed over, was covering for NA # 3's assignment, but that had not been the case. The DON stated the night shift NA, who stayed over, had been sent to another unit to cover a need there instead, and she had not been aware of that. The DON stated she first became aware on 5/18/19 at 11:30 AM that NA # 3 had not been replaced by another staff member. The DON confirmed there had not been anyone designated to provide an incontinent check and care for Resident #12, #13, # 15 and #16 prior to NA # 1 and NA # 2 providing incontinent care to them, and it was her expectation that all of these residents would have been checked for incontinence needs and care rendered prior to the times that they actually received care. According to a follow up interview with the DON on 5/18/19 at 3:10 PM, it was also her expectation that NA # 1 would have had time to recheck Resident # 14 before 10:25 AM on 5/18/19 following the resident's request at 7:10 AM.	F 725			