STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(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
E 000	Initial Comments An unannounce recertification survey was conducted on 8/5/19-8/8/19. The facility was in compliance with the requirements CRF 483.73. Emergency Preparedness Event ID 4CFI11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code pain management on the Minimum Data Set (MDS) assessment for 1 of 1 residents reviewed for Hospice service (Resident #26). Findings included: Resident # 26 readmitted to the facility on 11/20/18 with diagnoses that included alcoholic liver disease, adult failure to thrive, anxiety disorder and major depression disorder. Record review revealed Resident # 22 was admitted into the Hospice program on 3/29/19. Review of the quarterly MDS assessment dated 7/5/19 revealed Section J0100 for pain management was coded as not receiving any scheduled or as needed pain medication. Review of Resident # 26's medication administration record for the 7 day look back period for MDS assessment, dated 7/5/19 and for July - August 2019 revealed the resident received Morphine Sulfate ER Tablet Extended Release	F 641	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #26's care plan has been reviewed and updated to include Pain management according to his current status and medication orders. 2. All residents have the potential to be effected by the deficient practice. A facility wide audit has been conducted to ensure that all residents with orders for pain medications and regimens have a corresponding pain management care plan in place. 3. A. MDS Coordinator has been re-educated on the regulation that the assessment must accurately reflect thee resident's status. Care plan to be updated upon admission, quarterly, annually and as needed with any significant change in condition or medication change.	9/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2019

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F 641	Continued From page 1 (pain medication) 30 mg (milligram) twice a day and Morphine Sulfate Tablet 15 mg as need for pain management. The pain medication was administered as ordered and resident's pain was assessed as moderate to severe pain. During an interview on 8/6/19 at 2:26 PM, Nurse # 3 stated Resident # 26 received pain medication twice a day and as needed basis. Nurse # 3 further stated the resident's the pain was assessed every shift and when as needed medications were administered. The resident always complained of moderate to severe pain. During an interview on 8/8/19 at 9:05 AM, MDS nurse indicated the resident was on scheduled and on as needed pain medication during the 7 day look back period. Nurse stated she had made an error while completing the MDS assessment and had not marked resident for receiving pain medication. During an interview on 8/8/19 11:57 AM, the Administrator indicated it was his expectation that the resident's assessments were completed accurately and timely.	F 641	B. Resident care plans are to be reviewed and updated for completion and accuracy during the daily clinical meeting based on the following identifiers: admission, change in resident condition, new orders/medications, and incident reports. 4. DON/designee to audit 25% of residents receiving pain medications to ensure that their pain medication regimen corresponds to and matches their care plan. This audit will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		9/5/19

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F 656	Continued From page 2 assessment. The comprehensive care plan must describe the following - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop a comprehensive person-centered activity care plan that included measurable goals and individualized approaches for 1 of 2 cognitively impaired residents that needed assistance with activities (Resident #34).	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by	

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F 656	Continued From page 3 The findings included: Resident #34 was admitted to the facility on 3/12/18. The diagnoses included cognitive impairment, communication deficit and dementia. The significant change Minimum Data Set (MDS) dated 4/10/19, indicated Resident #34 was cognitively impaired and required total assistance with activities of daily living. The MDS did not code any resident interest or preferences, it was blank. Reviewed the last activity assessment dated 4/19/18. It did not document or indicate any interest by the resident. There was no activity notes available in over a year to indicate resident participation activities in the past year. Review of the care plan dated 4/22/19 identified the problem as Resident #34 had little or no activity involvement related to depression, immobility and physical limitations. The goal included Resident #34 would express satisfaction with type of activities and level of activity involvement when asked through the review date. The interventions included establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Explain to the Resident #34 the importance of social interaction, leisure activity time. Encourage the resident's participation by next review day. Invite/encourage the resident's family members to attend activities with resident in order to support participation. Remind the resident that Resident #34 may leave activities at any time and was not required to stay for entire activity.	F 656	provision of Federal and State regulations. 1. Resident #34's activity care plan has been reviewed and updated to include individualized goals, approached and interests in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. 2. All cognitively impaired residents have the potential to be effected by the deficient practice. An audit of all activity care plans has been conducted for all cognitively impaired residents to identify other residents having the potential to be affected. 3. The activity director (AD) has been educated to ensure each resident has an individualized activity care plan with individualized goals, approaches, and interests. AD to receive education on the requirement to review and update the activity care plan upon admission, quarterly, annually and as needed with any significant change in resident condition. AD to receive education on the requirement to provide documentation of participation in activities, including 1:1 activities and to include a quarterly summary of the each resident's participation in activities with their response to activities. A new activity documentation form has been created to promote adequate documentation of 1:1 and individualized resident activity participation. 4. The DON/designee is to audit 50% of cognitively impaired residents' care plans for completeness and accuracy, and the participation documentation records of those cognitively impaired residents. This	

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F 656	Continued From page 4 During an interview on 8/6/19 at 3:00 PM, the Activities Director (AD) stated the resident was in bed most of the time. Staff have done in room visits that included pet therapy, social interaction/conversation. Staff don't get the resident up for activities. Review of the activity attendance record for May 2 pet therapy, in room visits 11, June 1 pet therapy 10 in room visits and July 5 pet therapy. AD stated the Resident #34 liked pet therapy, general conversation. Review of the activity calendar for two days revealed several group activities Resident #34 could have participated but was not offered or attended. AD stated she did not write any quarterly notes explaining resident interaction or response. She added that the care plan does not explain frequency of when 1:1 activity would be done and what would be done. There was no system in place to identify and address one on one visits or when. AD stated the resident could benefit from all the activities presented on the calendar. AD stated "I have no system". AD stated she did not know why there was no measurable goals on the care plan. The care plan was done by another person. Act Director added there was no identified tracking system place to ensure which residents that were assigned 1:1 could be tracked. During an interview on 8/7/19 at 12:00 PM, the Administrator stated the expectation was to review the entire care plans for current resident issues with measurable goals and approaches to include resident specific areas and person centered. The care plans should be updated quarterly/annually for accuracy of service needed and/or discontinued. Review of the activities care plans revealed the goals did not reflect the resident assessments nor did they have	F 656	audit will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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F 656	Continued From page 5 measurable goals or approaches. During an interview on 8/7/19 at 1:58 PM, the Minimum Data Set (MDS) Nurse stated the expectation was for all departments to ensure residents care plan were resident specific /person center to resident needs with measurable goals and approaches. The care plan should be updated quarterly and annually to represent resident changes/progress and discontinued when appropriate. Review of the activities care plans Resident #34 ' s activity care plan for the identified revealed care plan, with the MDS nurse she stated the resident ' s care plan was revealed a standard plan for all residents and it was not person-center or resident specific based on resident assessment or activities of interest.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		9/5/19

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F 657	Continued From page 6 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility staff and hospice staff interviews, the facility failed to involve hospice representatives in the care planning process for 1 of 1 sampled residents reviewed for hospice services (Residents # 26). The findings included: Resident #26 was admitted to the facility on 11/20/18 with diagnosis that included adult failure to thrive, liver disease, anxiety disorder and major depression disorder. Review of the physician orders for hospice was dated 3/29/19. Review of Resident # 26's hospice plan of care dated 3/29/19 read in part - "Goals - A nursing plan of care will be established that meets the patient's needs. A chaplain plan of care will be established that meets the patient's needs. A medical social workers plan of care will be established that meets the patient's needs". There were no interventions included in the plan of care. Resident #26' s plan of care updated 6/28/19 included the focus area of hospice care. The	F 657	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #26's care plan has been updated to include hospice interventions and goals. A care plan conference has been scheduled with the resident's hospice agency for 9/5/2019. 2. All hospice residents care plans have been audited as all hospice residents have potential to be affected by the deficient practice. 3. MDS Coordinator has been educated on the requirement to ensure each hospice resident has a care plan addressing hospice goals and interventions. Social Services Coordinator has been educated on the requirement to collaborate services and care plans with the hospice agency representatives, including involvement and participation in regularly scheduled care plan conferences. Each contracted hospice agency has been informed in writing of the	

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F 657	Continued From page 7 goal indicated the resident would be comfortable. Interventions include encouraging family and friend visits; honor end of life wishes and to keep resident comfortable with medications. Review of the quarterly Minimum Data Set (MDS) dated 7/5/19 indicated Resident # 26 was cognitively intact, independent with supervision for activities of daily living (ADL). The MDS Assessment indicated the resident was on hospice care. During an interview on 8/8/19 at 9:05 AM, the MDS coordinator stated the social worker was responsible to invite the family and /or the resident and any other services to the care plan meeting. The MDS coordinator indicated the resident's care plan with focus area of hospice care was not reviewed with hospice team. MDS coordinator was not aware of the hospice services plan of care. The MDS coordinator stated she had visited the resident to discuss about the quarterly MDS and care plan in July 2019. The resident had refused the meeting. The MDS coordinator indicated whenever any resident refused a care plan meeting, the revised care plan was usually discussed in the morning meeting or during risk assessment meeting. This was treated as the care plan meeting. During an interview on 8/8/19 at 11:38 AM, the facility's social worker (SW) stated she was made aware of resident refusal. The SW stated as the resident refused to attend the care plan, the residents care plan review was done either during the morning meeting or during the risk management meeting. SW indicated no hospice staff have ever attended the care plan meeting. She stated she does receive information about	F 657	requirement to attend and participate in each care plan conference. 4. DON/Designee to audit 100% of the hospice care plans for goals and interventions, ensuring that each hospice resident has a care plan that shares common objectives and interventions with the associated hospice care plan. Attendance record of hospice resident care conferences will also be audited. Audits will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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F 657	Continued From page 8 Resident # 26 from the hospice contact person related to any change in medication or any other issues related to hospice. SW stated the hospice staff has their own care plan and was not sure if any staff knew about the hospice care plan. She was not sure if the staff were familiar with the hospice side of the care plan. During a telephone interview on 8/8/19 at 11:45 PM, the executive director of hospice service stated the resident was admitted to hospice service on 3/29/19. She indicated that the hospice has their own care plan, and the hospice staff reported any change in medication or concerns with the facility staff. She stated the hospice staff were not aware of any care plan meeting for the resident and were not invited. During an interview on 8/8/19 at 11:57 AM, the administrator stated the interdisciplinary team (IDT) team should meet for the care plan meeting and not have it in the morning meeting. The hospice staff should be involved in the care plan meeting and the plan of care should be developed with the participation of IDT, resident and/ or family members.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		9/5/19

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F 679	Continued From page 9 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the failed to provide on-going 1:1 activity for 1 of 2 sampled residents dependent upon staff structured activities. (Resident #34). The findings included. Resident #34 admitted to the facility on 3/12/18. The diagnoses included dementia, cerebrovascular accident and diabetes. The significant change Minimum Data Set (MDS) dated 4/10/19, indicated Resident #34 was cognitively impaired and required total assistance with activities of daily living. The MDS did not code any resident interest or preferences, it was blank. Reviewed the last activity assessment dated 4/19/18. It did not document or indicate any interest by the resident. There was no activity notes available in over a year to indicate resident participation activities in the past year. Review of the care plan dated 4/22/19 identified the problem as Resident #34 had little or no activity involvement related to depression, immobility a physical limitation. The goal included Resident #34 would express satisfaction with type of activities and level of activity involvement when asked through the review date. The interventions included establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Explain to the Resident #34 the importance of social interaction,	F 679	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #34's activity care plan has been reviewed and updated to include individualized goals, approached and interests in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. Resident is currently being provided 1:1 activity and is being appropriately documented. 2. All residents dependent upon staff structured activities have potential to be affected by the deficient practice. An audit of all activity care plans has been conducted for all residents dependent upon staff structured activities. 3. The activity director (AD) has been educated to ensure each resident has an individualized activity care plan with individualized goals, approaches, and interests. AD to receive education on the requirement to review and update the activity care plan upon admission, quarterly, annually and as needed with any significant change in resident condition. AD to receive education on the requirement to provide documentation of participation in activities, including 1:1 activities and to include a quarterly	

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F 679	Continued From page 10 leisure activity time. Encourage the resident's participation by next review day. Invite/encourage the resident's family members to attend activities with resident in order to support participation. Remind the resident that Resident #34 may leave activities at any time and was not required to stay for entire activity. Review of the August 2019 calendar the following activities were scheduled 8/5/19 10:00 Music, 10:30 Bible bingo, 11:30 AM Sittercise and 2:00 PM-4:00 PM UNO. Observation on 8/5/19 at 10:00 AM, the scheduled activity was Music and Resident #34 was in room with television on and she was not interested in the program. At 10:30 Bible Bingo, 11:30 AM Sittercise and 2:00 PM-4:00PM UNO was scheduled. Resident did not participate in any of the scheduled activities and staff did not offer or encourage or take resident to the activities. The resident was in her room the entire day. The Activities staff did not provide any 1:1 activity for the resident. On 8/6/19 at 10:00 Chat HR, 10:30 AM, Pet Therapy, 11:00 AM, Orientation, 11:30 Sittercise and 2:00 PM-4:00 PM Ring Toss. Observation on 8/6/19 at 10:30 AM, Resident #34 in room with television on and no sound. The scheduled activity was Pet Therapy; however, the activity did not occur. There was no alternate provided for the residents and there was no announcement that the activity was cancelled. The activity staff did not provide 1:1 activity for the resident. Observation on 8/6/19/19 at 11:30, Resident #34	F 679	summary of the each resident's participation in activities with their response to activities. A new activity documentation form has been created to promote adequate documentation of 1:1 and individualized resident activity participation. Nursing staff educated on requirement to encourage and assist residents who are depended on staff to attend activities. Staff and residents will be notified by an overhead page of any changes to the activity calendar and alternative activities will be provided in the event of cancellation. 4. The DON/designee is to audit 50% of activity care plans for residents who are cognitively impaired and or otherwise dependent upon staff for activity for completeness and accuracy, and the participation documentation records of those cognitively impaired residents. This audit will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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was in room with television on and no sound. Resident #34 was not encouraging or offered any activities by staff. There was no 1:1 provided. Observation on 8/6/19 at 2:00PM-4:00PM, the schedule activity was Ring Toss. Resident #34 was in room. The ring toss activity did not occur. There was no replacement activity provided and there was no announcement the activity was cancelled. Resident #34 was not provided any 1:1 activity.
On 8/7/19 10:00 AM, Music, 10:30 AM Devotion, 11:30 Orientation and 2:00 PM to 4:00 PM Bingo. On 8/8/19 at 10:00 Chat HR, 10:30 Snack, 11:00 Orientation, 11:30 Sittercise and 2:00 PM-4:00 PM Polish Nails. There was no scheduled time for residents to receive 1:1 activity for the Month of August.

During an interview on 8/6/19 at 3:00 PM, the Activity Director (AD) stated staff was expected to assist the activity department with transport to and from the activities. The AD further stated there was not enough staff or volunteers available to provide all the scheduled activities. The AD added there was no system in place to ensure residents on 1:1 were done consistently. She further stated cancellation of activities should be announced and alternates should be provided. The AD added that Resident #34 could benefit from participation in the currently provided activities. She added that Resident #34 would assistance with transportation to and from activities. In addition, the AD stated there was no current activity of interest assessment.

During an interview on 8/6/19 at 3:45 PM, NA#4 stated that when she arrived to work some residents were in activities. She was uncertain what activities. NA#4 reported there were not a lot

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of activities done in resident rooms and if activities in the evening were cancelled, residents or staff would not know.

During an interview on 8/6/19 at 3:50 PM, NA#1 stated she had not seen resident out of bed on second shift doing activities. NA#1 stated she had not seen much activities done in resident rooms. NA#1 indicated she was unaware of how residents, staff or family are made aware when activities were cancelled.

During an interview on 8/7/19 at 9:50 AM, NA#5 stated that resident is not normally taken to activities, due staffing issues and other work responsibilities. NA#5 stated activities don't start to 10:00 AM, and during those times aides were doing care and don't have enough time to get residents to activities. "I have not seen activities done much in resident rooms."

During an interview on 8/7/19 at 8/7/19 at 11:58 AM, Interim Director of Nursing (IDON)stated the expectation was for the aides to assist with transport to and from activities and encourage resident participate in activities. The IDON further stated the AD was responsible for ensuring all activities were provided as scheduled and inform everyone when activities were cancelled. The AD was also responsible for ensuring residents scheduled for 1:1 received them.

During an interview on 8/7/19 at 12:00 PM, the Administrator stated the Activity Director was responsible for having a system in place to ensure all activities was done as scheduled and cancellations should be announced and provide an alternate activity. In addition, the AD should also develop a system to ensure assessments

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F 679	Continued From page 13 were accurate and complete and 1:1 activity was being done.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review, the facility failed to apply left hand splint for 1 of 2 residents with contracture (Resident #13). The findings included: Resident #13 admitted on 6/22/18. Review of his annual Minimum Data Set (MDS) assessment, dated 6/5/19, indicated his intact cognition. Resident ' s diagnoses included left hand contracture and hemiplegia (paralysis of one side of the body). There was no splint/brace	F 688	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Resident #13's order for a left hand splint applied daily has been added to the resident's treatment administration record and in now being applied to resident's left hand daily. Resident's care plan has been updated to reflect the intervention.	9/5/19

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F 688	Continued From page 14 application indicated in the annual MDS assessment. Review of Resident 13 ' s plan of care, dated 4/11/19, revealed his limited physical mobility, with appropriate goals and interventions, included therapy referral and monitoring/documentation and reporting to physician the contracture forming or worsening. Review of the physician ' s orders for Resident #13 revealed the order, dated 4/30/19, indicated occupational therapy (OT) to evaluate and treat five times a week for eight weeks to address functional deficits in range of motion (ROM) of left upper extremity, with skilled interventions, included splint management. Record review revealed the occupational therapy discharge summary, dated 5/23/19, indicated the recommendation for the nursing floor to apply splint on left hand to manage contracture development. The OT staff trained the nursing staff to apply splint. Record review revealed Restorative Mobility documentation, dated August 2019, indicated the order for Resident #13 the left hand splint application for 2 to 4 hours to prevent contracture. Record review of the all nurses ' notes for July - August 2019, revealed no splint application documentation for Resident #13. Review of Resident 13 ' s Medication Administration Record and Treatment Administration Record for July - August 2019 revealed no documented splint applications.	F 688	2. 100% of residents with orders for contracture reduction/prevention devices has been conducted. All residents with orders for contracture reduction/prevention devices have the potential to be affected by the deficient practice. 3. All orders for contracture reduction/prevention devices have been added to each residents individual TAR in order to alert the nurse to apply the device as ordered. Any new orders will be reviewed and implemented in the daily clinical meeting and the care plan will be updated to reflect the intervention. Nursing staff to be educated on the new process. 4. DON/designee to audit 100% of residents with orders for contracture reduction/prevention devices to ensure order is accurate and reflected on the TAR and care plan. Audit will also verify physical application of the device on the resident. This audit will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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On 8/5/19 at 11:10 PM, during the observation/interview, Residents #13 was in bed, well dressed and groomed. There was no splint observed on his left hand or in his room. The resident indicated that he had splinting during OT in May 2019. After that, nobody applied the splint on his left hand.

On 8/6/19 at 1:10 PM, during the observation/interview, Residents #13 was in bed, well dressed and groomed. There was no splint on his left hand. The blue splint was observed in nightstand draw near the bed.

On 8/7/19 at 10:10 AM, during the observation, Resident #13 was in bed, well dressed and groomed. There was no splint applied on his left hand. The splint was in the draw of the nightstand near bed.

On 8/7/19 at 2:10 PM, during an interview, Nurse #1 indicated that resident had left side weakness, and did not receive hand splint.

On 8/7/19 at 2:55 PM, during an interview, Physical Therapist #1 (PT), indicated that Resident #13 received OT on 4/30/19 - 5/22/19 for left hand weakness and contracture. The resident tolerated left hand splint application for up to 4 hours to decrease pain and prevent further contracture development. In May 2019, at the end of his OT course, the therapy staff worked with nursing floor staff to teach them about resident ' s therapy needs, including left hand splint application.

On 8/7/19 at 3:10 PM, during an interview, Nurse Aide #1 indicated that she did not have assignment for left hand splint for Resident #13.

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F 688	Continued From page 16 She provided passive ROM daily, but no splint application. On 8/8/19 at 11:30 AM, during the observation/interview, Resident #13 was in his wheelchair in the activity room. He had splint applied on his left hand. The resident indicated that the staff applied the splint on his left hand this morning. On 8/8/19 at 12:10 PM, during an interview, Nurse Aide #2 indicated that she never observe Resident #13 with left hand splint. She received the assignment from the computer kiosk system and the splint was not among other tasks for this resident. On 8/8/19 at 12:20 PM, during an interview, Nurse Aide #3 indicated that Resident #13 did not have splint to apply on his left hand. She received the assignment from previous shift aides, who never mentioned splint. The nurse aide continued that in restorative book, on the nurses ' station, should be the document about resident ' s splint application details, but she did not see "anything like splint "for him. On 8/8/19 at 1:30 PM, during an interview, the Director of Nursing expected the staff on the floor to communicate with therapy department and follow the resident is splinting requirements, including staff training and splint application regiment.	F 688		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		9/5/19

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F 761	Continued From page 17 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to put label and date on one opened insulin injector and failed to remove expired one insulin multi-dose vial and one plastic container of Ibuprofen from 3 of 3 medication administration carts. Findings Included: 1a. On 8/5/19 at 10:45 AM, during the observation of the medication administration cart on the long hall with Nurse #2, there was one multi-dose vial of Humulin R (insulin), 100 units/ml (per milliliter), 3 ml. Per the label on the	F 761	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. All medication carts and storage rooms have been audited for proper storage of medications. All unlabeled and expired medications have been discarded. 2. All residents have the potential to be affected by the deficient practice. 3. All licensed nurses to be educated on	

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F 761	Continued From page 18 vial, it was opened on 5/23/19. Review of the manufacturer ' s literature/information (or package insert) recommended to discard the Humulin R 31 day after opening, which would have been on 6/23/19. On 8/5/19 at 10:50 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that the insulin vial was expired, but she did not use this medication during her shift. . The nurse had not check the expiration date on multi-dose vial of Humulin R in his medication administration cart at the beginning of the shift. b. On 8/5/19 at 10:55 AM, during the observation of the medication administration cart on the short hall with Nurse #3, there was one plastic container of Ibuprofen, 200 mg (milligram), 100 tablets, expired on 07/2019. 2. On 8/5/19 at 11:00 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that she did not use this medication during her shift. The nurse had not checked the expiration dates in her medication administration cart at the beginning of her shift. On 8/5/19 at 11:10 AM, during the observation of the medication administration cart on the rehabilitation hall with Nurse #4, there was Levemir Flex Touch insulin injector pen, 100 units/ml, 3 ml, opened, with no date of opening.	F 761	the proper storage, dating and labeling of medication. Daily Medication storage audit has been added to the daily assignment of the 2nd shift nurses. Any unlabeled or expired medication will be documented and discarded. 4. DON/designee to audit 100% of the medication carts and medication rooms to ensure proper labels and dates. This audit will be conducted weekly for 4 weeks, then monthly for 3 months. Results of the audits will be presented monthly to the QAPI committee to determine the need for continued monitoring and or training.	

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F 761	Continued From page 19 On 8/5/19 at 11:15 AM, during an interview, Nurse #4 indicated that the nurses, who worked on the medication carts, were responsible to mark the date of opening on the insulin injector pen and remove expired medications from the medication administration cart. The nurse confirmed that the insulin was opened but she did not use this medication during her shift. The nurse had not checked the insulin multi dose vial in her medication administration cart at the beginning of her shift. On 8/5/19 at 11:30 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to put date of opening on insulin pens and multi dose vials, check all the medications in medication administration carts for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.	F 761		