

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

PRINTED: 08/25/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345570	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/04/2021
NAME OF PROVIDER OR SUPPLIER HUNTERSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 13835 BOREN STREET HUNTERSVILLE, NC 28078		
(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	F 000			
F 600 SS=G	<p>A complaint investigation was conducted on 08/03/04 through 08/04/21. There were 2 allegations investigated and 1 was substantiated. Event ID HWS611.</p> <p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility neglected to provide incontinence care to a resident who was soiled with dried fecal matter and urine for 1 of 3 (Resident #2) residents reviewed for activities of daily living. The resident stated that her bottom was burning and stinging so badly and all she could think about was "sitting in hot water and soaking her rear end."</p> <p>The findings included: Resident #2 was admitted to the facility on</p>	F 600		8/24/21	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electronically Signed					08/25/2021

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 600	<p>Continued From page 1</p> <p>04/10/20 with diagnoses that included dementia, diabetes, and anxiety.</p> <p>A care plan updated on 07/18/20 read in part, potential for skin impairment related to bowel incontinence. The goal read; resident will have no evidence of skin impairment through the next review. The interventions included: keep skin clean and dry, lotion to dry skin, moisture barrier cream as needed for protection of skin, peri care with incontinent episodes, pressure reduction mattress, and weekly skin assessments</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 06/08/21 revealed that Resident #2's cognition was not assessed, and she required total assistance with toileting. The MDS further revealed that Resident #2's pain was not assessed, and she was always incontinent of bowel and bladder. No pressure ulcers or moisture associated skin damage were noted during the assessment reference period. No behaviors or rejection of care were noted on the MDS.</p> <p>A continuous observation of Resident #2 was made on 08/03/21 from 10:42 AM to 11:20 AM. Resident #2 was resting in bed with a sheet and comforter covering her. The sheet and comforter were folded down and there was brown fecal matter noted on the bed sheet and pad that was under Resident #2. There was a dried brown/pink ring noted on the pad under Resident #2 that extended from her lower back area to behind her knees in addition there was dried brown fecal matter noted to Resident #2's outer left thigh. Resident #2 stated, "it is stinging and burning how about giving me a bath." Resident #2 was observed to have egg pieces under her neck and</p>	F 600	<p>deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F600</p> <ol style="list-style-type: none"> How corrective action will be accomplished for those residents found to have been affected: Resident # 2 was provided incontinence care and bathing along with a complete bed linen change and gown change with barrier cream applied after incontinence care provided How the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential of being affected by this practice. All residents are provided incontinence care on care rounds by the nursing department and as needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing or designee will educate all nursing employees on providing incontinence care timely. The Director of Nursing or designee will check 10 residents for incontinence care before meals 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks to ensure that incontinence care is being provided timely. All nursing employees will be educated upon hire in orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at 		

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F 600	Continued From page 2 when near Resident #2 a very strong odor of ammonia and feces was noted. At 10:46 AM assistance was requested from the staff for Resident #2. Resident #2 continued to state her bottom was burning and stinging so bad. At 10:49 AM NA #1 entered Resident #2's room and Resident #2 stated "I need my bottom cleaned, I am sitting on food." NA #1 replied she needed to gather some supplies and exited the room. Resident #2 hollered out "Jxxxx Cxxxxx it's burning can't you do something quickly. Coming back means never." NA #1 returned to the room at 11:00 AM and Resident #2 stated "Gxx it is killing me "Bring me some hot water and help." NA #1 was observed to get a pan of water with wash cloths and began washing Resident #2's face, Resident #2 stated "I need you to wash my rear end." NA #1 continued to wash Resident #2 and removed her soiled gown which was noted to have a large ring approximately 10 inches wide and brown in color that was dried. When NA #1 pulled the covers off of Resident #2 the odor of ammonia and feces was very prevalent. The soiled brief that Resident #2 had on was heavily soiled to where the liquid and stool had come through the plastic material on the outside of the brief. The contents had leaked through Resident #2's gown, pad, sheet and onto her air mattress which NA #1 had to clean before turning Resident #2 onto her back again. Resident #2 entire buttocks area was noted to be beefy red with scratch marks visible. There was some skin peeling along the buttock crack. With each wipe of the washcloth on her bottom by NA #1 Resident #2 would holler out ouch that hurts or ouch that is burning and stinging. Once clean NA #1 applied a barrier cream to Resident #2's entire buttock and peri area. NA #1 explained that when she arrived at work, she was scheduled to work	F 600	the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed 5. Date of compliance: 8/24/2021		

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F 600	<p>Continued From page 3</p> <p>on a different unit in the facility and was pulled to Resident #2's unit around 10:00 AM. NA #1 stated that she had not provided any care to Resident #2 since arriving on the unit but added that night shift would have changed her before they left for the day. Once Resident #2 was clean and dry with clean bed sheets and linen NA #1 gathered her supplies and exited the room. Resident #2 was asked if she felt better, and she replied "yes."</p> <p>NA #2 was interviewed on 08/03/21 at 12:05 PM. NA #2 confirmed that she was the other NA working the unit where Resident #2 resided. She stated that when she reported to work at 6:45 AM and received report from NA #3. She was told everyone has been changed and was good to go and then NA #3 left the unit because her shift was over. NA #2 stated she believed there would be 3 NAs on the unit, so she had started her normal round. She stated that she realized after getting started that she was the only NA on the unit when the breakfast trays arrived. NA #2 stated that she began passing out and setting up the trays on the unit. She confirmed that she delivered and set up Resident #2's breakfast tray. NA #2 stated that she did not check Resident #2 for incontinence issue prior to or when she delivered her breakfast tray, and she was not aware that she needed care. She set the tray up and exited Resident #2's room. NA #2 went on to say that NA #1 arrived on the unit around 10:00 AM after breakfast was over and the trays had been collected and returned to dietary. She stated once NA #1 arrived on the unit they split the unit up and they each began to care for their assigned residents. NA #2 stated that Resident #2 was the responsibility of NA #1 and she had not provided any care to Resident #2.</p>	F 600			

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F 600	Continued From page 4 NA #3 was interviewed on 08/03/21 at 3:40 PM. NA #3 confirmed that she had worked on Resident #2's unit the previous night from 11:00 PM to 7:00 AM and provided care to her. NA #3 explained that they did a round at 11:00 PM and made sure everyone was dry and did not need incontinent care and then they let the resident sleep through night unless they used their call light for assistance. NA #3 explained at 4:00 AM they began to complete the last round of the night and got to Resident #2 around 4:45 AM. She stated that Resident #2 was wet, and they provided incontinent care, applied barrier cream to her bottom, got her fresh ice water and tidied her room and let her return to sleep. NA #3 reported off to NA #1 that Resident #2 had been dried and was good to go at change of shift at 6:45 AM. Nurse #1 was interviewed on 08/03/21 at 1:00 PM. Nurse #1 confirmed that he was caring for Resident #2. He stated that Resident #2 remained on air mattress due to a history of pressure ulcers. Currently Nurse #1 stated that Resident #2 had some moisture associated skin damage on her buttock and described it as the entire buttock was red and Resident #2 was known to frequently scratch that area. Nurse #1 stated that Resident #2 routinely received Calazime (barrier cream) to her buttocks every day and routinely complained of her bottom hurting but with her impaired cognition could not fully assess her pain. Nurse #1 stated that when Resident #2 would complain of her bottom hurting, he would give her Hydroxyzine (antihistamine) and that would calm her itching and relieve her discomfort.	F 600			

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F 600	<p>Continued From page 5</p> <p>The Unit Manager (UM) was interviewed on 08/03/21 at 1:30 PM. The UM stated that the NAs were expected to do a walking round each morning when giving report. She stated that she could not say when Resident #2 had been cared for last but stated she should have been checked at the very minimum before her breakfast tray was delivered and set up to her. She stated she expected all the residents including Resident #2 to be checked and care provided to ensure they were not soiled in this case during the breakfast meal. The UM confirmed that there were some issues with staffing that morning but had not realized that NA #1 had not arrived at the unit until after breakfast was over.</p> <p>The Director of Nursing (DON) was interviewed on 08/03/21 at 1:50 PM. The DON stated that she would not be concerned if Resident #2 was yelling out or that would not automatically make the staff go into her room because she often did that. She went on to explain that she did not have facility acquired pressure ulcers in the facility and that indicated to her that the staff were providing good incontinence care and turning the residents frequently. Given that information she believed she had one time event that she needed to ensure did not become a common occurrence. The DON stated that the NAs did not do walking rounds and those would be more easily implemented with the Nurses than with the NAs but stated they had to do a better job of checking on resident to make sure they did not have an immediate care need. The DON confirmed that they had some staffing issues that morning and she had pulled NA #1 from a different unit to help NA #2 on the unit where Resident #2 resided.</p> <p>The Administrator was interviewed on 08/04/21 at</p>	F 600			

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F 600	Continued From page 6 11:39 AM. The Administrator stated that they had management conduct daily rounds on each resident. She stated that the manager that rounded on Resident #2 on 08/03/21 had been in her room around 9:30 AM but did not notice any smell or issue that would have raised question that Resident #2 required an immediate care need but did not negate the fact that Resident #2 needed care.	F 600			
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 the presence of a pressure ulcer on the Minimum Data Set (Resident #1) and failed to code cognition and pain on the Minimum Data Set (Resident #2) for 2 of 3 residents reviewed for activities of daily living. The findings included: 1. Resident #1 was admitted to the facility on 03/12/21 and was discharged on 04/12/21. Resident #1's diagnoses included: congested heart failure, atrial fibrillation, acute respiratory failure, and others. Review of a Weekly Skin Assessment completed on admission dated 03/12/21 indicated that Resident #1 had a wound present that was pressure related and the sacral wound measured 1.0 x 1.5 and treatment was initiated. The assessment was completed by Unit Manager	F 641	F641 1. How corrective action will be accomplished for those residents found to have been affected by the same deficient practice: Per 2567, Based on record review and staff interview the facility failed to accurately code the presence of a pressure ulcer on the Minimum Data Set (Resident #1) . Weekly Skin Assessment completed on admission dated 03/12/21 indicated that Resident #1 had a wound present that was pressure related and the sacral wound measured 1.0 x 1.5 and treatment was initiated. The pressure wound was documented in the 3/12/21 weekly skin assessment. Resident #1's 3/16 Adm/5d MDS was not coded as having a pressure ulcer nor was it addressed in the CAA. Resident #1	8/24/21	

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F 641	<p>Continued From page 7 (UM) #2.</p> <p>The comprehensive Minimum Data Set (MDS) dated 03/16/21 revealed that Resident #1 was moderately impaired for daily decision making and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #1 had no pressure ulcer but did have skin tears. The MDS was completed by MDS Nurse #1.</p> <p>Review of the Care Area Assessment (CAA) for pressure ulcers dated 03/17/21 read in part, will proceed to care plan to maintain skin integrity to prevent development of pressure ulcers. Resident is on a pressure relieving mattress and skin is observed during care. No pressure ulcer reported in the look back period. Staff will monitor and report any skin impairments. The CAA was completed by MDS Nurse #1.</p> <p>MDS Nurse #2 and MDS Nurse #3 were interviewed on 08/03/21 at 4:27 PM. MDS Nurse #2 explained that MDS Nurse #1 was no longer with the company. MDS Nurse #3 stated that on admission UM #2 noted the wound to be pressure in origin but in another note another nurse called it a skin tear which created a discrepancy. MDS Nurse #3 confirmed that the CAA did not mention the pressure ulcer to the sacral region and stated that if MDS Nurse #1 had conflicting assessments of the area that Resident #1 had then she should have gotten it clarified so the MDS could have been accurately coded and should have been addressed in the CAA as well.</p> <p>The Director Of Nursing (DON) was interviewed on 08/03/21 at 5:07 PM. The DON stated that she would expected the assessments to be</p>	F 641	<p>discharged home on 4/12/2021 and has not returned to Huntersville Health and Rehab Center.</p> <p>Per 2567, based on record review and staff interview the facility failed to code cognition and pain on the Minimum Data Set (Resident #2) for 2 of 3 residents reviewed for activities of daily living. Resident #2 MDS interview for cognition and pain was missed. Resident #2 cognition and pain MDS interview was completed with on 8/3/21 by MDSC.</p> <p>2. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 8/24/2021, all current residents <input type="checkbox"/> most recent comprehensive MDS and will be reviewed to determine if the pressure ulcer was coded accurately on the MDS along with the triggered Pressure Ulcer CAA to ensure the CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to a pressure ulcer. By 8/24/2021, all current residents <input type="checkbox"/> most recent MDS will have a cognition and pain interview completed on their most recent MDS.</p> <p>3. How facility plans to monitor its performance to make sure that solutions are sustained: MDSC Consultant will provide education to MDSC on coding of Section M and Pressure Ulcer CAA completion per RAI Manual by Friday 8/24/21. Also, by 8/24/21, review with MDSC timely completion of cognition and pain interview per RAI Manual.</p>		

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F 641	<p>Continued From page 8</p> <p>completed accurately and if there was a discrepancy then someone should have sought resolution so the MDS could have been coded accurately.</p> <p>UM #2 was interviewed on 08/03/21 at 6:03 PM. UM #2 confirmed that she admitted Resident #1 to the facility on 03/12/21 and had assessed her skin upon admission. UM #2 confirmed that upon admission to the facility Resident #1 had a pressure ulcer to her sacral area and she had initiated a treatment.</p> <p>2. Resident #2 was admitted to the facility on 04/10/2020 with diagnoses that included: dementia, hypertension, hypothyroidism, diabetes, and anxiety.</p> <p>The comprehensive Minimum Data Set (MDS) dated 06/08/21 revealed that Resident #2's cognition had not been assessed nor had the staff assessment of Resident #2's cognition been completed, and dash marks were noted throughout the questions. The MDS further revealed that Resident #2's pain had not been assessed nor had the staff assessment of Resident #2's pain been completed, and dash marks were noted throughout the questions. The MDS did reveal that Resident #2 required extensive to total assistance with activities of daily living. The MDS had been completed by MDS Nurse #4.</p> <p>MDS Nurse #2 and MDS Nurse #3 were interviewed on 08/03/21 at 4:27 PM. MDS Nurse #2 explained that MDS Nurse #4 was a traveling MDS nurse that completed Resident #2's MDS remotely. MDS Nurse #3 stated that those assessments for Resident #2 were not completed</p>	F 641	<p>4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS Consultant will audit 5 residents with documented pressure ulcer and stage to ensure comprehensive MDS is coded correctly and addressed in Pressure Ulcer CAA for review 1 week for a total of 4 weeks, twice monthly for 1 month, then 1 time a month for one month. MDS Consultant will audit 5 residents to ensure cognition and pain interview is completed timely for review 1 week for a total of 4 weeks, twice monthly for 1 month, then 1 time a month for one month.</p> <p>5. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.</p> <p>6. Completion date: 8/24/2021</p>		

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F 641	Continued From page 9 so when MDS Nurse #4 went to complete the MDS remotely she did not have the information and therefore did not code the information on the MDS. MDS Nurse #2 and #3 confirmed that it was their responsibility to enter those assessments and complete them timely so that the assessments could be used to accurately complete the MDS, and both agreed it was just an oversight on their part. The Director of Nursing (DON) was interviewed on 08/03/21 at 5:07 PM. The DON stated she expected the MDS nurses to complete the required assessments that would be used to accurately code the MDS and if they were unable to complete them, they should have flagged them for one of the other managers to complete.	F 641			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to clean a dependent resident's fingernails before allowing her to eat finger foods for 1 of 3 residents reviewed for activities of daily living (Resident #2). The findings included: Resident #2 was admitted to the facility on 04/10/20 with diagnoses that included dementia. A care plan revised on 11/03/20 read in part, the	F 677	F677 1. How corrective action will be accomplished for those residents found to have been affected: Resident # 2 was provided incontinence care and bathing along with a complete bed linen change and gown change with barrier cream applied after incontinence care provided on 8/3/2021 Resident # 2 nail care was provided by unit manager on 8/3/2021	8/24/21	

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F 677	<p>Continued From page 10</p> <p>resident has an activity of daily living self-care performance deficit related to impaired balance, limited mobility, decreased cognitive function, possible side effect of opioid and psychoactive medication. The goal read; Resident #2 will participate in activity as daily living as she is able through next review. The interventions included: personal hygiene per one staff member.</p> <p>Review of the Minimum Data Set (MDS) dated 06/08/21 revealed Resident #2's cognition was not assessed and indicated Resident #2 required extensive assistance with personal hygiene and required set up assistance with eating. The MDS also revealed no behaviors or rejection of care were noted during the assessment reference period.</p> <p>An observation was made on 08/03/21 at 10:42 AM of Resident #2. Resident #2 was resting in bed with a sheet and comforter covering her. The sheet and comforter were folded down and there was brown fecal matter noted on the bed sheet and pad that was under Resident #2. In addition, there was dried brown fecal matter noted to Resident #2's outer left thigh. Resident #2's fingernails on both hands were approximately ¼ inch long and all were noted to have dried brown substance under them. At 11:00 AM Nurse Aide (NA) #1 entered the room to provide care to Resident #2. NA #1 washed Resident #2's face, hands, body and legs and provided incontinence care but did not clean the dried brown substance from under Resident #2's fingernails.</p> <p>An observation and interview were conducted with NA #1 on 08/03/21 at 1:10 PM. NA #1 was observed to carry Resident #2's lunch tray into Resident #2's room. NA #1 was observed to sit</p>	F 677	<p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential of being affected. All residents will be offered nail care by 08/24/2021. 100 percent audit of all residents will be completed by the Director of Nursing or designee to ensure nail care provided by 08/24/2021.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing or designee will educate all nursing employees on providing incontinence care timely. The Director of Nursing or designee will educate all nursing staff to ensure nail care is provided and proper hand hygiene is performed before setting meal tray up. The Director of Nursing or designee will check 10 residents for incontinence care and for hand hygiene and nail care before meals 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks to ensure that incontinence care, nail care and proper hand hygiene is being provided timely. All nursing employees will be educated upon hire in orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed.</p> <p>5. Date of compliance 8/24/2021</p>		

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F 677	<p>Continued From page 11</p> <p>the tray on her bedside table and got a washcloth and wet it. NA #1 then went to Resident #2 and proceeded to wash her hands with the wet washcloth and then handed Resident #2 a dinner roll off her lunch tray to her right hand without cleaning the dried brown substances from under her nails. Resident #2 was observed to eat the roll with her right hand and with each bite the roll was in contact with the dirty fingernail that contained dried brown substances. NA #1 stated that she had not noticed the dried brown substance under Resident #2's fingernails earlier in the shift or when washing her hands for lunch or she would have cleaned them and trimmed them.</p> <p>An observation of Resident #2 was made on 08/03/21 at 1:20 PM. Resident #2 was resting in bed and was noted to have fingernail clippings on her gown and bed. Unit Manger (UM) was at bedside had just finished trimming Resident #2's nails and exited the room.</p> <p>The UM was interviewed on 08/03/21 at 1:30 PM. The UM stated that she was asked to check on Resident #2 and noted her fingernails were long and dirty, so she trimmed them. The UM stated that the NAs were able to clean and trim Resident #2's fingernails and could do so anytime they noted them to be long or dirty.</p> <p>The Director of Nursing (DON) was interviewed on 08/03/21 at 1:50 PM. The DON stated that she expected Resident #2's fingernails to be cleaned before eating her lunch tray. She further stated that the staff could clean and trim Resident #2's fingernails anytime they were noted to be dirty or long but certainly during care.</p>	F 677			

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F 725 F 725 SS=G	Continued From page 12 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 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide sufficient nursing staff to provide incontinence care to a resident who was soiled with dried fecal matter and urine and failed to clean a dependent resident's fingernails before allowing her to eat finger foods for 1 of 3 (Resident #2) resident	F 725 F 725	F725 1. How corrective action will be accomplished for those residents found to have been affected: Resident # 2 was provided incontinence care and bathing along with a complete	8/24/21	

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F 725	<p>Continued From page 13 reviewed for staffing.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>F600: Based on observation, record review, and staff interviews the facility neglected to provide incontinence care to a resident who was soiled with dried fecal matter and urine for 1 of 3 (Resident #2) residents reviewed for activities of daily living. The resident stated that her bottom was burning and stinging so badly and all she could think about was "sitting in hot water and soaking her rear end."</p> <p>F677: Based on observation, record review and staff interview the facility failed to clean a dependent resident's fingernails before allowing her to eat finger foods for 1 of 3 residents reviewed for activities of daily living (Resident #2).</p> <p>Nurse Aide (NA) #1 was interviewed on 08/03/21 at 11:15 AM about staffing and she indicated she did not wish to discuss the staffing situation at the facility.</p> <p>NA #2 was interviewed on 08/03/21 at 12:05 PM. NA#2 stated that they often worked short because the staff would call in or not show up. She indicated that generally they ran 3 NAs on the unit where she worked but on 08/03/21 she was the only NA on the unit until 10:00 AM when NA#1 came to assist but at that point they were so far behind that it was almost impossible to catch up. She indicated that she delivered breakfast trays and set up everyone to eat and then checked on those residents that could not feed themselves and then collected the breakfast</p>	F 725	<p>bed linen change and gown change with barrier cream applied after incontinence care provided</p> <p>Resident # 2 nail care was provided by unit manager</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential of being affected. All residents will be offered nail care by 08/24/2021. 100 percent audit of all residents will be completed by the Director of Nursing or designee to ensure nail care provided by 08/24/2021. All residents are provided incontinence care on care rounds by the nursing department and as needed.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>Director of nursing or designee will educate all nursing staff that if they are unable to complete all tasks assigned, they will immediately notify the Administrator or Director of Nursing. The Director of Nursing or designee will educate all nursing employees on providing incontinence care timely. The Director of Nursing or designee will educate all nursing staff to ensure nail care is provided and proper hand hygiene is performed before setting meal tray up. The Director of Nursing or designee will check 10 residents for incontinence care and for hand hygiene before meals 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks to ensure that incontinence care is being provided</p>		

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F 725	<p>Continued From page 14</p> <p>tray by herself before NA #1 arrived to help.</p> <p>The Unit Manager (UM) was interviewed on 08/03/21 at 1:30 PM. The UM stated that she was unaware of the staffing situation that had occurred earlier on the shift, she stated that she thought they had 2 to 3 NAs on the unit where Resident #2 resided along with an orientee. She was unaware that NA #1 did arrive to the unit until after breakfast and that NA #2 was working by herself.</p> <p>The Director of Nursing (DON) was interviewed on 08/03/21 at 1:50 PM. The DON stated that the facility was contracted with 3 staffing agencies and they utilized what they could from those agencies but like every other place staff was scarce. She stated she had hired NAs that she did not feel like were a good fit just to have a staff member. The DON added that the facility had recently implemented shift differentials for the various shift to encourage staff member to work over or pick up extra shifts. She added that when she realized that there was a staff member that was not at work, she pulled NA #2 and orientee to go help on the unit where Resident #2 resided because those residents required a lot more hands on care than the short-term rehab residents. The DON added that staff members were tired and the last year had been rough on everyone, but they needed everyone to step up to the plate and pitch in to care for the residents. The DON stated if a team member was unable to complete their assignment, they needed to ask for assistance from her or a management team member so that everything that needed to be done got done.</p>	F 725	<p>timely.</p> <p>The Director of Nursing or designee will monitor staffing and the timely notification of call-outs 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks to ensure staff scheduled is able to provide care.</p> <p>All nursing employees will be educated upon hire in orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed.</p> <p>5. Date of compliance 8/24/2021</p>		