| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345286 | A. BUILDING _____ B. WING _____ | 06/29/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| THE CITADEL SALISBURY | 710 JULIAN ROAD SALISBURY, NC 28147 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0565<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Honor the resident's right to organize and participate in resident/family groups in the facility.**<br><br>Based on record review and resident and staff interviews, the facility failed to resolve repeated concerns reported during Resident Council meetings related to snacks not being offered at bedtime, not having enough coffee at breakfast, and Nurse Assistants (NA)s not always being available after 8:00 PM for 3 of 3 consecutive months of resident council meetings (April 2020, May 2020 and June 2020). Findings included: The Resident Council Meeting Minutes from April 3, 2020 to June 12, 2020 were reviewed. The review revealed the following concerns were voiced during the monthly Resident Council Meetings and the facility's response. The Resident Council Meeting Minutes from April 3, 2020 specified concerns related to: A. Snacks not being offered at 8:00 PM B. Difficulty finding NAs after 8:00 PM C. Shortage of coffee in the morning for breakfast The facility's response for these concerns were recorded on the response form for the April 3, 2020 meeting and did not address the resident concerns regarding not enough coffee at breakfast, evening snacks not being offered or NAs not being available to help after 8:00 PM. The Resident Council Meeting Minutes from May 14, 2020 specified concerns related to: A. Snacks not being offered at 8:00 PM. B. Difficulty finding NAs after 8:00 PM C. Shortage of coffee in the morning for breakfast The facility's response for these concerns were recorded on the response form for the May 14, 2020 meeting that they would be placing an extra coffee on breakfast carts, with no mention of how the facility was going to resolve the resident's concerns related to the NAs not being available after 8:00 PM or snacks not being offered. The Resident Council Meeting Minutes from June 12, 2020 specified concerns related to: A. Snacks not being offered at 8:00 PM. B. Difficulty finding NAs after 8:00 PM C. Shortage of coffee in the morning for breakfast The facility's response for these concerns were recorded on the response form for the 06/12/20 meeting that an extra urn of coffee would be placed on the breakfast carts and NA concerns and snacks were not addressed on the response form. An interview with the Resident Council President (Resident #12) was done on 06/24/20 at 12:46 PM. He stated that concerns related to residents not being offered an evening/bedtime snack, not having enough coffee at the breakfast meal and NA staff not being available after 8:00 PM continued. The resident stated, if anything is said to the staff, they made an excuse such as I am the only one on the unit, but that didn't help the situation. During an interview with Resident #11, who usually attended resident council meetings, on 06/23/20 at 12:47 PM, he stated he was not pleased with the care or the follow up for his concerns by the facility. He stated if the staff respond to his call light, they come in and turn it off and don't come back in. An interview was conducted with Resident #3 on 06/24/20 at 5:41 PM. She stated resident concerns were not handled in a manner to correct them. An interview was done with the Assistant Activity Director on 06/29/20 at 11:50 AM. She stated if residents had concerns at the Resident Council meeting, she wrote it on a form and sent it to the appropriate department. The Director of Nursing was interviewed on 06/29/20 at 2:22 PM. She was asked about the process with concerns from the resident council. She stated that the concerns were written on paper and given to her to address. The Director of Nursing stated she worked with the call light issue and had conducted audits on how long it took the NA to respond. She said for the call lights she audited, the NA had stayed in the room when the call light was answered and handled the concern and she had seen the response getting better. An interview was completed with the administrator about the resident council process on 06/29/20 at 4:34 PM. She stated if a concern was voiced by the residents during the monthly RC meeting the staff were to complete a follow up form and those get reviewed at the next resident council meeting with updates on how their previous complaint was handled. When asked about the residents not receiving their nightly snacks, her expectation was that staff would offer snacks in the evening. When asked about the coffee, she stated that dietary started putting two containers on the cart a few weeks ago. The administrator said that she felt that resident concerns were being addressed and it was getting better. |
| F 0585<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, resident and staff interviews the facility failed to make prompt efforts to resolve resident grievances for 2 of 2 sampled residents (Residents #1 and #3) reviewed for grievances. Findings included: The facility policy on Filing Grievances/Complaints, revised on April 2017, stated that residents .have the right to file grievances, either orally or in writing to the facility staff and the administrator and staff will make prompt efforts to resolve the grievances to the satisfaction of the resident. 1. Resident #1 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) completed on 01/29/20 for Resident #1 indicated she was cognitively intact with no behaviors. A review of the facility's grievance log for 02/01/20 through 06/20/20 noted Resident #1 had grievances on 02/22/20 regarding a broken cell phone and on 05/16/20 for medications given late. The grievance sheet for the late medications showed the grievance was resolved. An interview was conducted with Resident #1 on 06/23/20 at 12:55 PM. She stated the administrator was aware of several of her concerns including; a stolen thermometer, medications not being received, and medications being administered later than scheduled. The resident said the administrator did not address her concerns or write them up as a grievance. She also noted one of her family members had spoken with the administrator this week when nothing was done regarding her concerns. The resident stated the facility had not resolved these concerns to her satisfaction. On 06/29/20 at 11:23 AM an interview was conducted with Nurse #6. She said that Resident #1 frequently had concerns about her meds not being given on time and incorrect medications being given. The nurse stated she listened to her and tried to explain the medication times. Nurse #6 stated, grievance forms were not completed to address Resident #1's concerns. An interview with the Director of Nursing (DON) was conducted on 6/29/20 at 2:22 PM. When the DON was asked about Resident #1's concerns, about a stolen thermometer and her medications being administered late or not at all; the DON stated, the resident frequently voiced concerns and she did not write them up. During an interview with Social Worker (SW) #1 on 06/29/20 at 11:38 AM she stated that Resident #1's family member had filed a grievance last week related to medications not being given at the proper time, correct medication not being administered, diet, lying in a wet bed and not responding to the call lights, cell phone not working, the follow up appointment for her eyes, and the status of the resident transferring from the facility. The Social Worker stated the DON had left a voice mail on 06/22/20 and 06/24/20 with the resident's family member to follow up. An interview was completed with the administrator on 06/29/20 at 4:34 PM. The Administrator stated she was the facility's grievance coordinator and she should be aware of all grievances voiced by residents and/or their families. She stated she expected staff and management to write up grievances. The administrator was aware of several grievances voiced by Resident #1. The administrator stated that if residents voice a grievance to staff, the staff member is expected to write them up. 2. Resident #3's was admitted to the facility on [DATE]. A review of the Quarterly MDS from |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0585<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>04/15/20 indicated Resident #3 to be cognitively intact. A review of the facility's grievance log for 02/01/20 through 06/20/20 noted Resident #3 had a grievance logged from 05/14/20 regarding nursing care and drink requests. The grievance reported noted the grievance to be resolved on 05/14/20. An interview was conducted with Resident #3 on 06/24/20 at 5:41 PM. The resident voiced concern that, she told Nurse #3 during the morning of 06/24/20 that she had concerns about not getting her 5:00 PM medications yesterday. She stated this happened once a week. She said everyday it is something, medications or they are out of briefs, or pull-ups or gloves. She stated she cannot find anyone to tell the concerns to, and she wanted to discuss her complaints with management. She said no one had come to speak with her about her concerns that day and they likely would not. She stated that she was concerned the facility's current management don't care about the residents and their concerns were not handled. An interview was completed with Nurse #3 on 06/29/20 at 8:43 AM. The nurse stated, last week Resident #3 informed her that she wanted to file a grievance about her medications and nursing care. Nurse #3 said, she made the Director of Nursing (DON) aware of the resident's concerns. An interview was conducted with SW #1 on 06/29/20 at 11:06 AM, who assisted with resident grievances. She stated that the administrator was the grievance coordinator. The social worker stated she would help but did not handle the nursing grievances. The SW said any staff member should be able to write up a grievance and if the person was new, she would assist them in filling it out if needed. She reviewed the log for 06/21/20-06/27-20 and no grievances were recorded for Resident #3. An interview with the Director of Nursing (DON) on 06/29/20 at 2:22 PM revealed she was aware that Resident #3 had a complaint about not receiving her medication on 6/24/20, but the Medication Administration Record [REDACTED]. She stated she waited to check with the nurse when she returned to work on 06/26/20. When asked if she followed up with the resident, the DON stated she was busy, but she believed she told the resident she had received her medications. The DON stated she didn't write Resident #3's concern up as a grievance. An interview was completed with the administrator on 06/29/20 at 4:34 PM. The Administrator stated she was the facility's grievance coordinator and she should be aware of all grievances voiced by residents and/or their families. She stated she expected staff and management to write up grievances. The administrator was not aware of grievances for Resident #3. The administrator stated that if residents voice a grievance to staff, the staff member is expected to write them up. |
| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interviews, the facility failed to utilize a sling lift during a resident transfer for one of three residents reviewed for accidents. While being transferred without the use of a sling lift Resident #4 was lowered to the floor and indicated she was having pain in her leg. The resident was transferred to the hospital for evaluation and treatment and it was determined she had experienced a right tibia (front leg bone below the knee) and right fibula (rear leg bone below the knee) fractures. The findings included: Resident #4 Was admitted to the facility on [DATE] and her cumulative [DIAGNOSES REDACTED]. A review of Resident #4 ' s Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 4/17/20. The resident was coded as having severe cognitive impairment. For Activities of Daily Living (ADLs) the resident was coded as having been totally dependent of two or more people for bed mobility. The resident was coded as not having walked in her room, in the corridor, transferred (such as transitioning from the bed to a wheelchair, moved about in her room, the hall, the unit she was on, or throughout the building, during the assessment period. Continued review revealed the resident dressed only 1-2 times during the assessment period and was assisted by one person. The resident was coded as being assisted by one person and was totally dependent for toilet use, personal hygiene, and bathing. A Nurse Practitioner (NP) progress note dated 5/11/20 revealed Resident #4 was documented as continuing to recover from COVID-19. The resident ' s insulin coverage had been discontinued because of the resident ' s poor intake and her intake was slowly normalizing. The resident ' s weight was documented as having been 214.4 pounds. The resident ' s lung sounds were recorded as having been diminished throughout the lung fields. Resident #4 ' s care plan, which had been reviewed and updated on 5/27/20 contained a focus area for ADL care which specified the resident required assistance for ADLs including transfers. The intervention listed the resident was to be provided assistance by 2 staff members for transfers using a sling lift. Review of Resident #4 ' s Electronic Medical Record revealed there was no evidence of a Transfer/Mobility evaluation prior to 5/29/20. An NP progress note dated 5/28/20, and timed 3:07 PM, revealed Resident #4 resident was documented as having experienced a fall while transferring which resulted in a malformation of the right lower leg. The resident was being transferred by nursing staff from her bed to a chair when the fall occurred. The documentation continued orders were given to provide pain medication and to send the resident to the emergency room (ER). An incident report for Resident #4, which was dated 5/28/20, and timed 1:30 PM. The report specified the nursing staff stated after assisting the resident out of the bed to get into a shower chair while in the resident ' s room. The resident locked her legs, then began to buckle her leg, the resident was lowered to the floor. The resident was documented as immediately stating she could not move her leg and she was hurting. The report documented the resident ' s physician was notified and the resident was sent to the hospital for further evaluation. A witness statement, dated 5/29/20, was written by the Rehabilitation Manager (RM) specified Nurse #1 approached her about Resident #4 on 5/28/20. She documented per the Certified Occupational Therapist Assistant (COTA), therapy had been working with the resident on stand, pivot, sit transfers, and therapy was planning to get the resident out of bed on 5/28/20. A phone interview was conducted on 6/25/20 at 10:41 AM with the Rehabilitation Manager (RM). The RM stated the Occupational Therapist (OT) was mostly working with Resident #4, but the Certified Occupational Therapy Assistant (COTA) was going to work with the resident on the day the resident fell . The RM stated she had worked with the resident about a year ago and at that time the resident had difficulty standing and she had to be placed in a standing frame (a therapy device used to stand residents up securely) in order to stand. The RM stated she was working with the resident regarding Occupational Therapy and for strengthening, the arm bike, and trunk coordination/strengthening. The RM stated when she was working with the resident, prior to her fall on 05/28/20, she required pretty maximal effort on the part of the therapist to complete the exercise and strengthening routines. The RM stated the OT had tried a stand, pivot, sit transfer with the resident, but every time she had tried it, there was a sling lift pad under her, but only once or twice. The RM explained the OT was working more with the resident on sitting up, getting to the side of the bed, and going from lying down to sitting up. The RM said Occupational Therapy had picked the resident up on 5/12/20. She said she felt like the resident was getting weaker and more dependent through the period therapy was working with her before the fall, because the resident had become maximum assistance even to get her to the side of the bed. The RM further stated the resident did not have a transfer goal, such as to become more independent on transfers, or a goal to increase tolerance being out of bed. The RM recalled the day the resident fell (on 5/28/20), she explained Nurse #1 came to her and had originally asked if therapy would mind getting Resident #4 out of bed. The OT stated that she agreed she would assist the resident out of the bed while Nurse #1 was there. The RM stated she was then made aware the resident had fallen. The RM explained it was not the typical process for a nurse to come to the rehabilitation gym to ask about transferring a resident and then go transfer the resident themselves. The RM stated unless there was documentation completed about a resident being upgraded for a transfer, such as from a sling lift to a stand, pivot, sit transfer, the staff aren ' t supposed to transfer a resident other than what is in the evaluation or care plan. The RM further stated the therapy department usually would work with a resident for a long time before upgrading their transfer method. The RM stated the OT reported to her earlier in the week, before Resident #4 ' s fall, an NA had asked her how Resident #4 transferred, and the NA was informed resident was being transferred by using the sling lift. A witness statement, written by Nurse #1, dated 5/28/20 specified, she had spoken with the RM about Resident #4 transferring with a stand, pivot, sit transfer. The nurse documented the RM spoke with the COTA and verified therapy had been working with the resident on pivoting. The statement continued while transferring the resident from the bed to a shower chair, and during the transfer the resident buckled, and was assisted to the floor. While the resident was on the floor she complained of right knee/leg pain and swelling/redness was observed. An interview was conducted on 6/24/20 at 2:46 PM with Nurse #1. The nurse stated it was her first time transferring Resident #4 on 5/28/20 and she said prior to that Physical Therapy (PT) had worked with the resident. The nurse stated she talked to one of the therapy personnel, she couldn ' t remember who, but the person in therapy told her the resident was able to transfer, stand, pivot, sit transfer. The nurse further stated she was assisting the NAs to get the resident up, everything was explained to the resident, they sat her on the side of the bed, the resident was assisted to a standing position, and her legs gave out from under her. The nurse said they slid the |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>resident to the floor, and that was when they saw her leg was hurt. A witness statement written by Nursing Assistant (NA) #1, dated 5/28/20 was reviewed. She documented Nurse #1, NA #2, and her were assisting Resident #4 with a transfer from the bed to a shower chair and when the resident stood, her legs gave out, and the resident was assisted to the floor. She further documented the resident ' s leg appeared abnormal after assisting the resident to the floor. An interview was conducted with NA #1 on 6/24/20 at 2:22 PM. She stated NA #2, Nurse #1, and herself were transferring Resident #4 to the shower chair. She explained the nurse was on the right, NA #2 was on the left, and she was behind the resident. The NA stated when they stood the resident up, her knees gave out, her right leg went under her as she was lowered to the ground. The NA. She continued to explain the resident ' s right leg did not look right, a nurse, and the resident ' s physician looked at the resident ' s leg and then the resident was sent to the hospital. The NA stated Resident #4 was usually not her resident. The NA stated someone had told NA #2 the resident had been standing in therapy, and that she could stand up, pivot, and sit. The NA stated the resident used her wheelchair to get around her room and around the facility. The NA further stated there were information sheets at the nurses ' station which told how residents were transferred but she had not checked to see how the resident transferred. A witness statement by NA #2, dated 5/28/20, was reviewed. The NA documented a nurse, another NA, and herself were transferring Resident #4 to the shower chair and the resident ' s legs gave out and she was lowered to the floor and her right leg was under her. During an interview conducted on 6/24/20 at 2:08 PM with NA #2 she stated she was with Resident #4 when the resident fell . The NA stated NA #1, Nurse #1, and she were assisting the resident out of the bed to the shower chair, the resident stood up, then sat, then stood again, while they were pivoting the resident to the shower chair, the resident was unable to support herself, and they lowered the resident to the floor. The NA stated after the resident was lowered to the floor, she could see her right leg was bent. The NA stated the resident typically transferred with two people, but when some second shift nursing staff arrived later in the day, they told her the resident transferred with the sling lift. The NA stated there was information on a sheet at the nurses ' station in which the resident was documented as a two person assist for transfer and the sheet had not been updated the resident was a sling lift. During an interview with NA #2 conducted on 6/24/20 at 3:03 PM she stated the NA Assignment Sheets, which would indicate how a resident was to be transferred, were available at the nurse ' s station. The NA was unable to locate the NA Assignment Sheets at the 100, 200, 300 hall nurse ' s station. Review of hospital records dated 5/28/20, and timed 4:39 PM, for Resident #4 revealed the resident was seen in the ER and the resident was discovered to have had an acute mildly displaced proximal tibia and fibula fractures to the right leg through radiological exam.<br>During an interview with the Unit Manager (UM) conducted on 6/24/20 at 1:04 PM, she stated Resident #4 was transferred via the sling lift before her fall and she wouldn ' t have tried to stand her up. She stated she thought therapy was working with the resident before the resident fell . An interview was conducted on 6/24/20 at 2:52 PM with the Certified Occupational Therapy Assistance (COTA). She stated Resident #4 had not been on PT caseload since 2019, but the resident was currently on Occupational Therapy (OT) caseload and she was working with the resident before she fell . The COTA stated they were not working on transfers with the resident. She said they were working on the resident ' s strength and endurance for other activities such as working toward the edge of the bed and upper body strengthening. The COTA further stated she felt the resident safest transfer option was a sling lift transfer prior to and after the fall. An interview was conducted with the MDS Coordinator on 6/24/20 at 4:28 PM. The MDS Coordinator stated to her knowledge Resident #4 was a sling lift with the assistance of two people and that was what the resident was care planned for. The MDS Coordinator stated after the resident fell , there were conversations with therapy that therapy was working on a stand pivot sit transfer with the resident but it had not been cleared with the nurse on the hall for the Resident to have been a stand, pivot, sit transfer. The MDS Coordinator stated the paper care plan in the resident ' s chart had the resident as a two person sling lift and that was not changed. The MDS Coordinator stated she reviewed and verified the care plan after the resident fell , and it was in the care plan the resident was a two person transfer with a sling lift. The MDS coordinator explained she was not aware of a reason for the resident having been transferred with a stand, pivot, sit transfer at the time of the fall. The MDS Coordinator also stated information about the kind of transfer a resident was, was on the NA Assignment Sheets, and the information on the assignment sheets was updated by the ward clerks. The MDS Coordinator further stated she had been at the facility for almost a year and Resident #4 had been a sling lift with the assistance of two people the whole time she had been at the facility. An interview was conducted with the Director of Nursing (DON) on 6/24/20 at 4:49 PM. The DON stated she was at the facility the Resident #4 fell . She stated she went down to the room after the resident had fallen and the resident was sent out to the emergency room (ER) immediately to evaluate the injury she sustained from the fall. The DON explained the nursing staff who had transferred the resident had spoken with therapy and discovered therapy was working with the resident with a stand, pivot, sit, transfer. The DON further stated through her investigation it was discovered when the staff members stood the resident up, the resident felt weak, and they helped to assist and lower the resident to the floor. The DON said when she interviewed the nursing staff who were transferring the resident, they said they had asked therapy how the resident was being transferred, which was a stand, pivot, sit, and that was how they transferred her. The DON stated the nursing staff who transferred the resident, which included a Registered Nurse (RN), utilized an interdisciplinary team approach and attempted to transfer the resident. During a phone interview conducted on 6/26/20 at 10:14 AM with the Nurse Practitioner (NP) of Resident #4, she stated it was her understanding the facility staff was utilizing a sling lift to transfer the resident. In addition, the NP stated, the resident had been diagnosed as having COVID, was symptomatic (meaning she experienced ailments related to [MEDICAL CONDITION]), deconditioned (physical decline in condition), and had gotten weaker all related to having contracted [MEDICAL CONDITION]. The NP explained, even if the resident did transfer prior to COVID via stand, pivot, sit, she was weakened to the point where it would have reasonable to expect her to have been transferred via a sling lift. A phone interview was conducted with the Administrator on 6/26/20 at 11:28 AM. The Administrator stated she believed the nurse looked at the care plan in the electronic medical record, which had documented the resident was a dependent transfer, and she and two NAs who did not know Resident #4 went and discussed the resident ' s transfer status with therapy. The nursing staff discovered through conversation with therapy, therapy was doing a 2 person stand, pivot, sit transfer. The nursing staff attempted the stand, pivot, sit transfer, the resident ' s knee buckled, and the staff lowered the resident to floor. The Administrator stated they have re-evaluated every resident ' s transfer status, nursing staff have been in-serviced about how to identify how to properly transfer residents and proper transfer techniques, all facility staff who participate in transfer can always downgrade a resident to a safer transport option, such as a lift, audits have been conducted regarding transferring lifts per their evaluation, and they have reviewed the audits and the incident in their Quality Assurance (QA) meetings as well as have instigated a Quality Assurance Process Improvement (QAPI) regarding transferring residents safely. The corrective action for past non-compliance dated 5/28/20 was as follows: Problem Identified: Employees transferred Resident #4 from her bed to her shower chair in her room. The resident ' s right knee buckled, and she was lowered to the floor. The resident incurred a fracture to the right leg. Resident was care planned as a 2 person transfer and staff did follow the care plan. The Medical Director was in the facility at the time and saw the resident. The Nurse Practitioner was notified, and pain medication was ordered. An order was obtained to send the resident to the emergency room for evaluation. The resident returned with an order for [REDACTED]. An audit was conducted on 100% of current residents using the Transfer/Mobility Evaluation tool to determine each resident ' s transfer ability safely. An audit was completed on 5/29/20 by the DON, Unit Manager, and hall nurses. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: After completion of Transfer/Mobility Transfer tool of each resident. The Interdisciplinary Team will discuss each resident, update the care plan, and communicate transfer ability to staff via Plan of Care (POC) or NA Assignment sheets at the nurses ' station. Address what measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future. Staff were re-educated on safe transfer, skills validation was completed for safe transfer using the gait belt, sling lift, sit to stand, and wheelchair transfer. Education was provided by the Assistant Director of Nursing (ADON), DON, and the Staff Development Coordinator (SDC) starting May 29, 2020. Education and Competencies will be provided upon new hire in orientation. The Hall Nurse will document on the 24 hour report if there is a change in the resident ' s ability to transfer. The Interdisciplinary Team will review and discuss change in clinical and RISK meeting. Therapy referral as needed, update care plan, POC, and NA Assignment sheet. 100% of nursing staff were re-educated on safe transfer and competencies with a date of completion of 6/2/20. Indicate how the facility plans to monitor it performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The administrator and the DON, ADON, SDC, UM will observe safe transfers 5 times weekly for 2 weeks, |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>then 3 times weekly for 6 weeks. The Administrator will report findings to the monthly Quality Assurance process improvement committee to ensure compliance. The Administrator is responsible for overseeing this process. As part of the validation process on site from 6/22/30 through 6/23/20 and off site from 6/24/20 through 6/29/20, the plan of correction was reviewed including the re-education of staff. Interviews with nursing staff (licensed and nursing assistants) revealed they were retrained in the area of safe transfers. A review of the monitoring tools revealed that the facility completed the audit of falls as noted in their POC. 100% of in-servicing of nursing staff was completed on 6/2/20 including NA #1, NA #2, and Nurse #1 who had assisted moving Resident #4 on 5/28/20. A review of the facility audits revealed the audits were being performed on a weekly basis with no concerns identified. The facility's final correction date was validated as 6/2/20. |
| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on staff interview and record review, the facility failed to ensure accurate medical records for the documentation of administered medications for 4 of 4 residents reviewed for medication administration. (Residents #1, #8, #9 and #10).<br>Findings included: 1. Review of the Medication Administration Record [REDACTED]. An interview was done with the Director of Nursing (DON) on 06/24/20 at 4:39 PM regarding the medication administration process. She stated they knew they have a problem with medications not being documented accurately. The DON stated she had just discussed it with their educator, and they would begin staff education. 2. A review of the Medication Administration Record [REDACTED]. These medications were not documented as being given for the 12:00 AM dose on 02/25/20, the 6:00 AM dose on 02/26/20 or the 12:00 pm dose on 02/24/20, 02/25/20, 02/26/20 or 02/27/20. A review of the MAR for Resident #8 for February 2020 indicated the medication Montelukast for asthma was not documented as being given on 02/13/20 and 02/16/20. A review of the MAR for Resident #8 for 02/07/20-02/29/20 indicated a medication used to treat Parkinson disease was not documented as being given on 02/7/20, 02/13/20, 02/19/20, 02/20/20, 02/24/20, 02/25/20, 2/27/20 or 02/28/20. A review of the MAR for Resident #8 from 02/07/20-02/15/20 indicated [MEDICATION NAME], the medication to treat tissue swelling was not documented as being administered for the 6:00 PM dose on 02/07/20, 02/13/20 and 02/14/20. [MEDICATION NAME], a medication to treat high blood pressure ordered daily to be given, was not documented as being administered on 02/11/20, 02/14/20, or 02/24/20-02/28/20. A review of the MAR for Resident #8 for February 13, 2020 indicated the medication to treat [MEDICAL CONDITION], an irregular cardiac rhythm and ordered to be given twice daily was not documented as being given for either dose. Also, Eliquis, a blood thinner to prevent clots and ordered to be given twice daily was not documented for either dose on 02/13/20, 9:00 AM dose 02/14/20 and 02/28/20. A review of the MAR for Resident #8 indicated the medication Potassium, ordered daily and used to treat low blood levels was not documented as being administered on 02/11/20, 02/27/20 or 02/28/20. An interview was done with the Director of Nursing (DON) on 06/24/20 at 4:39 PM regarding the medication administration process. She stated they knew they have a problem with medications not being documented accurately. The DON stated she had just discussed it with their educator, and they would begin staff education. 3. Review of the Medication Administration Record [REDACTED]. The medication was due to be given on 02/21/20. A medication error report for Resident #9 was completed on 02/24/20 by a staff member and noted the Director of Nursing (DON) was notified that the medication for [MEDICAL CONDITION] was not signed out and given as ordered on [DATE]. An interview was done with the Director of Nursing (DON) on 06/24/20 at 4:39 PM regarding the medication administration process. She stated they knew they have a problem with medications not being documented accurately. The DON stated she had just discussed it with their educator, and they would begin staff education. 4. A review of the Medication Administration Record [REDACTED]. [MEDICATION NAME], a daily medication to treat diabetes was not documented as being given on 02/14/20. Magnesium, a medication for low blood levels, [MEDICATION NAME] Ropinrole for restless leg syndrome were also not documented on 02/14/20. An interview was done with the Director of Nursing (DON) on 06/24/20 at 4:39 PM regarding the medication administration process. She stated they knew they have a problem with medications not being documented accurately. The DON stated she had just discussed it with their educator, and they would begin staff education. |