STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345128	A. BUILDING _____ B. WING _____	C 06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

(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 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, and staff interview, the facility failed to post survey results 3 of 4 days of the survey. The findings included: Observations revealed a sign posted in the front lobby by the receptionist desk that survey results were located in the lobby. Observations on 06/15/15 at 12:09 PM revealed the surveyor could not locate the survey results in the lobby. There was an empty wooden hanging receptacle located on the wall by the entrance door under the clock. The survey results could not be located in the lobby during observations on 06/15/15 at 5:15 PM; 06/16/15 at 7:45 AM and 5:45 PM; and on 06/17/15 at 7:40 AM, at 1:30 PM and at 4:18 PM. On 06/17/15 at 4:25 PM the resident council president stated during interview that he thought the survey results were in the front lobby but he had never looked for them.	F 167	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 167 Right to Survey Results-Readily Accessible Criteria 1 Survey Results binder returned to its designated accessible location in the front lobby on 6/17/2015. Resident Council President told by Administrator on 6/18/2015 that Survey Results binder had been returned. Criteria 2 All residents of the facility have the	7/17/15

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

Electronically Signed | 07/12/2015

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F 167	Continued From page 1 On 06/17/15 at 5:30 PM, survey results were observed in the wooden hanging receptacle by the front entrance. On 06/17/15 at 6:00 PM the Administrator stated he had seen the survey results this date sitting on the desk of the receptionist and hung it up in the wooden receptacle. He stated he did not know why they were not on the wall accessible to the residents. Follow up interview with the administrator on 06/18/15 at 10:56 AM revealed he was responsible for making sure the survey results were updated and accessible to the residents and families. He did not know who took them off the wall in the lobby.	F 167	potential to be affected by this alleged deficient practice. Criteria 3 Administrator or designee to verify in daily rounds that Survey Results binder is in designated accessible location daily for four weeks then weekly for 8 weeks. This verification is to be documented on a written log by the Administrator or designee. Criteria 4 Resident Council President has agreed to allow Administrator to remind the Council of the Survey Results binder location for the next three monthly meetings of resident council. Documentation of Survey Results binder rounds will be presented monthly at Facility Quality Assurance Committee Meeting. Date of Compliance: July 17, 2015	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain wheelchair	F 246	F 246 Reasonable Accommodation of Needs/Preferences	7/20/15

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F 246	Continued From page 2 seating to allow for self propelling per an Occupational Therapy referral for 1 of 1 resident reviewed for positioning (Resident #10). The findings included: Resident #10 was admitted on 02/12/10 with diagnoses including congestive heart failure and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 03/12/15 revealed Resident #10 had severely impaired cognition and required extensive with transfers and supervision for locomotion off unit. The quarterly MDS noted walking did not occur and Resident #10's mobility device was a wheelchair. Review of the medical record revealed Resident #10 received Occupational Therapy services for wheelchair positioning from 02/11/15 through 04/07/15. Review of the Occupational Therapy discharge summary revealed Resident #10 was evaluated and provided with a new wheelchair seat cushion with installed drop seat in which the anterior portion was higher than the posterior portion to decrease episodes of sliding out. A support was added to the right side of the wheelchair to prevent her from leaning to the right. The discharge summary also noted Resident #10 was able to spontaneously self propel her wheelchair up to 100 feet with her legs. Observations of Resident #10 during the survey revealed the following: - On 06/15/15 at 3:47 PM Resident #10 was sitting in her wheelchair across from the nurse's station with both of her feet approximately 1 inch	F 246	Criteria 1 Corrective action was accomplished for the alleged deficient practice by the Licensed Therapist completing a wheelchair modification for Resident #10 on 06/18/2015. Criteria 2 Residents positioned in a wheelchair have the opportunity to be affected by this alleged deficient practice. The Rehab Manager and Licensed Therapist will conduct an audit of residents utilizing a wheelchair to validate appropriate positioning in the wheelchair. This audit will be completed by 7/17/15. Opportunities will be corrected as identified. Criteria 3 The Rehab Program Manager and the Director of Nursing will re-educate Nursing staff on the method for completing a therapy referral for wheelchair positioning by 7/20/15. The Rehab Program Manager or Licensed Therapist will randomly observe 10 residents per week for 12 weeks to verify appropriate wheelchair positioning. Opportunities will be corrected as identified. Criteria 4 The results of these audits will be presented by the Rehab Manager monthly for 3 months at Facility Quality Assurance	

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F 246	Continued From page 3 off the floor. - On 06/15/15 at 4:31 PM Resident #10 was sitting in her wheelchair across from the nurse's station with her legs crossed at the ankles. Both of her feet approximately 1 and 1/2 inches off the floor. - On 06/16/15 at 8:56 AM Resident #10 was sitting in her wheelchair in the dining room with her legs crossed at the ankles. Both of her feet approximately 1 and 1/2 inches off the floor. - On 06/17/15 at 3:04 PM Resident #10 was sitting in her wheelchair across from the nurse's station with her legs crossed at the ankles. Both of her feet approximately 1 and 1/2 inches off the floor. - 06/18/15 at 7:51 PM Resident #10 was sitting in her wheelchair in the dining room with her legs crossed at the ankles. Both of her feet approximately 1 and 1/2 inches off the floor. - 06/18/15 at 10:42 AM Resident #10 was sitting in her wheelchair across from the nurse's station with both of her feet approximately 1 inch off the floor. An interview with the Rehabilitation Program Manager on 06/18/15 at 10:59 AM revealed that correct sitting posture was composed of right angles at the knees, hips, and elbows. The interview further revealed the goal for wheelchair seating was for the resident to have stable upright posture with their feet touching the floor. During an interview on 06/18/15 at 12:30 PM Nurse Aide (NA) #4 stated it was important for	F 246	Committee Meeting. The committee will make changes or recommendations as indicated. Date of Compliance: July 20, 2015	

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residents to sit up straight in their wheelchairs with their feet flat on the floor. NA #4 further stated Resident #10 leaned to the right side in her wheelchair and had a support cushion on the right side of her wheelchair to assist with positioning. NA #4 confirmed she was assigned to care for Resident #10 that day and had not noticed if her feet were flat on the floor when she was seated in her wheelchair or if Resident #10 had self propelled in her wheelchair.

An interview was conducted on 06/18/15 at 12:35 PM with the Occupational Therapist (OT) who had Resident #10 on her caseload from 02/11/15 through 04/07/15. The OT stated Resident #10 was provided with a new wheelchair seat cushion with installed drop seat in which the anterior portion was higher than the posterior portion to decrease episodes of sliding out. The OT noted the drop seat was lowered an additional 2 to 3 inches which allowed Resident #10's feet to touch the floor and made it possible for her to self propel in her wheelchair.

On 06/18/15 at 12:40 PM the OT was accompanied to the dining room to observe Resident #10. The outer edge of Resident #10's left shoe was touching the floor and her right foot was approximately 1/2 inch off the floor. Two folded towels were observed under the wheelchair seat cushion. The OT noted the towels raised the seat cushion and would prevent Resident #10 from self propelling in her wheelchair.

A follow up interview with NA #4 on 06/18/15 at 12:49 PM revealed she had not placed the towels under Resident #10's wheelchair cushion but recalled NA #5 had mentioned doing so.

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F 246	Continued From page 5 During an interview on 06/18/15 at 2:23 PM NA #5 stated Resident #10 did self propel occasionally. NA #5 further stated she had put a towel under Resident #10's wheelchair seat cushion awhile back to lift the front of the seat cushion so she would not slide forward as much. The interview further revealed NA #5 did not discuss putting the towels under the seat cushion with the nurse or the therapy department. An interview with the Director of Nursing (DON) on 06/18/15 at 4:59 PM revealed NAs should not make adjustments to wheelchair seating established by therapy.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		7/20/15

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F 272	Continued From page 6 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors for 2 of 10 sampled residents reviewed for the most recent comprehensive Minimum Data Set (Residents #135 and #118). The findings included: 1. Resident #135 was admitted on 02/12/15 with diagnoses including mood disorder, anxiety disorder, and chronic pain. Review of the comprehensive Minimum Data Set (MDS) dated 02/23/15 revealed Resident #135 had severely impaired cognition, unclear speech, was sometimes understood, and usually understands. The comprehensive MDS indicated Resident #135 exhibited verbal behavior directed toward	F 272	F 272 Comprehensive Assessments Criteria 1 Corrective action was accomplished for the alleged deficient practice for Residents #118 and #135 by the Resident Care Management Director completing and submitting significant corrections to prior comprehensive assessments to include updated Care Area Assessments on 07/13/2015. Criteria 2 All residents of the facility have the potential to be affected by this alleged deficient practice. Criteria 3 The Resident Care Management Director (RCMD) re-educated all MDS and Interdisciplinary team members	

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F 272	Continued From page 7 others and rejection of care which occurred 1 to 3 days during the 7 day assessment period. The comprehensive MDS noted verbal complaints of pain the last 5 days. Review of the Care Area Assessment (CAA) Summary revealed Psychosocial Well-Being and Behavioral Symptoms both triggered and would be addressed in a care plan. a. Review of Resident #135's CAA Summary for Psychosocial Well-Being dated 03/11/15 indicated she had a history of altered mental status as evidenced by physician's notes and the history and physical. Documentation in the analysis of findings stated Resident #135 was combative with staff and refused and pocketed medications. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Psychosocial Well-Being CAA Summary. During an interview on 06/18/15 at 6:21 PM the Social Worker (SW) confirmed she had completed Resident #135's CAA Summary for Psychosocial Well-Being for the comprehensive MDS completed on 02/23/15. The SW stated she had completed MDS training on the computer and did not include a narrative in the analysis of findings which documented the description of the problem, causes and contributing factors, and related risk factors because she did not know it was required. The SW further stated no one had ever pointed out to her she was not completing CAA Summaries correctly. b. Review of Resident #135's CAA Summary for Behavioral Symptoms dated 03/11/15 indicated she was combative with staff and refused and pocketed medications as evidenced by nursing	F 272	responsible for completing MDSs on 7/15/15. This education included instructions on documenting descriptive Care Area Assessments (CAAs) according to the RAI Manual. The RCMD will randomly audit 10 completed comprehensive assessments weekly for 12 weeks to validate descriptive CAAs. Opportunities will be corrected as identified as a result of these audits. Criteria 4 The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility Quality Assurance Committee Meeting. The committee will make changes or recommendations as indicated. Date of Compliance: July 20, 2015	

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notes. Supporting documentation noted Resident #135 had a history of altered mental status as evidenced by physician's notes and the history and physical. Documentation in the analysis of findings stated Resident #135 was combative with staff and refused and pocketed medications. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Behavioral Symptoms CAA Summary.

During an interview on 06/18/15 at 6:21 PM the Social Worker (SW) confirmed she had completed Resident #135's CAA Summary for Behavioral Symptoms for the comprehensive MDS completed on 02/23/15. The SW stated she had completed MDS training on the computer and did not include a narrative in the analysis of findings which documented the description of the problem, causes and contributing factors, and related risk factors because she did not know it was required. The SW further stated no one had ever pointed out to her she was not completing CAA Summaries correctly.

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2. Resident #118 was admitted to the facility on 02/19/15. Her diagnoses included end stage renal disease, seizure disorder, diabetes, depression, left femoral fracture, joint contractures and pneumonia. Resident #118 received dialysis.

The admission Minimum Data Set (MDS) dated 03/01/15 coded her with intact cognitive skills, requiring extensive assistance with most activities of daily living skills (ADLs) including bed mobility, toileting, dressing, and transfers occurred only once or twice. She was also coded with being unable to stabilize herself during surface to surface transfers without human assistance and having unstageable pressure ulcers. Resident #118 was coded with a history of falls with fractures prior to this admission and receiving occupational and physical therapies. She was also coded as receiving a therapeutic diet. The MDS noted areas that triggered a Care Area Assessment (CAA) included the areas of ADL Function, Falls, Nutritional Status, and Pressure Ulcers. These CAAs, completed 03/20/15 by MDS Nurse #1, failed to include an analysis of the information that described the description of the problem, the impact of the problem on the resident's functionality, the causes, contributing factors, and risk factors as follows:

a. Review of the ADL Functional/Rehabilitation Potential CAA revealed a check box system with some narrative notes. Narrative information included this area was an actual problem due to impaired mobility, she was receiving therapy,

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psychoactive medications, had pressure ulcers, and was occasionally incontinent. The description of the problem/need on the resident stated the resident needed extensive assistance with ADLs at this time, she had weakness and received dialysis weekly.

b. Review of the Fall CAA revealed a check box system with some narrative notes. Narrative information included this area was an actual problme and the resident was at risk for falls, had history of falls, received psychoactive medication, had weakness, unsteady gait, impaired mobility and was receiving therapies. The description of the problem/need on the resident stated the resident needed assist with transfer and mobility, had weakness and unsteady gait.

c. Review of the Nutrition CAA revealed a check box system with some narrative notes. Narrative information included this area was a potential problem as the resident received a mechanical soft diet, was at increased risk for skin breakdown due to having pressure ulcers, had no significant weight loss and received dialysis weekly. There was no description of the impact of the problem/need on the resident, only what the care plan would address as interventions.

d. Review of the Pressure Ulcer CAA revealed a check box system with some narrative notes. Narrative information included this area was an actual problem as the resident had pressure ulcers to her feet, a history of deep vein thrombosis, a diagnosis of diabetes, was at risk for falls and had a history of falls. There was no description of the impact of the problem/need on the resident, only what the care plan would address as interventions.

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F 272	Continued From page 11 On 06/18/15 at 5:15 PM an interview was conducted with the MDS Director and MDS Coordinator. The MDS staff who completed Resident #118's CAAs was on vacation and unavailable for interview. MDS Director and MDS Coordinator stated that the CAA computer system was set up that it automatically used a check box system in which some things would be automatically checked and staff could check other pertinent items. Staff were expected to identify the problem for the resident and complete a summary of how the problem affected the resident. Review of the CAAs completed for Resident #118 with the MDS Director revealed the CAAs did not analyze the information for the triggered issues. MDS Director stated the MDS staff who completed these CAAs worked part time and when first employed, MDS Director reviewed her CAA summaries and noted she was writing paragraphs that described the impact of the problem on the resident. She further stated she had not reviewed MDS staff's CAAs recently and Resident #118's CAAs needed more information and analysis.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		7/20/15

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F 278	Continued From page 12 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set accurately to reflect hospice care for 1 of 1 resident reviewed for hospice care (Resident #42) and accurately reflect behaviors for 1 of 1 residents reviewed for behaviors (Resident #147). The findings included: 1. Review of the medical record revealed Resident #42 was admitted on 09/30/13 with diagnoses including Alzheimer's dementia, diabetes mellitus, and chronic obstructive pulmonary disease. Further review of the medical record revealed hospice services were initiated on 10/03/14 due to Alzheimer's disease. Review of a significant change Minimum Data Set (MDS) dated 10/13/14 revealed the section titled "Special Treatments, Procedures, and Programs"	F 278	F 278 Assessment Accuracy/Coordination/Certified Criteria 1 Corrective action was accomplished for the alleged deficient practice for Residents #42 MDS with ARD 4/3/15 to accurately reflect Hospice and Resident #147 MDS with ARD 3/26/15 to accurately reflect behaviors on 7/9/15. The Resident Care Management Director completed these modifications to correct the keying errors on 6/22/2015. Criteria 2 All Residents receiving Hospice Services and residents exhibiting Behaviors have the potential to be affected by this alleged	

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	345128	A. BUILDING _____ B. WING _____	C 06/18/2015

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F 278	Continued From page 13 was checked for hospice care. The Care Area Assessment (CAA) Summary for cognitive loss/dementia completed on 11/19/14 stated Resident #42 had a diagnosis of Alzheimer's disease and continued with memory impairment and impaired decision making skills. The CAA summary further noted Resident #42 was placed on routine hospice services on 10/03/14. Review of a quarterly MDS completed on 01/07/15 revealed the section titled "Special Treatments, Procedures, and Programs" was checked for hospice care. Review of a quarterly MDS completed on 04/03/15 revealed the section titled "Special Treatments, Procedures, and Programs" was not checked for hospice care. An interview was conducted with the MDS Director on 06/18/15 at 6:06 PM. The MDS director confirmed Resident #42 was currently receiving hospice services. The MDS Director stated Resident #42's quarterly MDS dated 04/03/15 was completed by the part-time MDS nurse and should have been checked for hospice care. The interview further revealed the MDS Director had reviewed the part-time MDS nurse's assessments for the first three to four weeks after she was hired in February 2015 but did not recall reviewing Resident #42's quarterly MDS dated 04/30/15. The part-time MDS nurse was not available for interview during the recertification survey.	F 278	deficient practice. An audit of MDSs completed during the last 30 days was completed by the Resident Care Management Director to verify accurate assessment of those receiving Hospice Services and those with observed behaviors and corrections completed as identified. This audit was completed by 7/16/15. Criteria 3 The Resident Care Management Director (RCMD) re-educated the Interdisciplinary team and MDS staff on accurate MDS coding related to Hospice Services and Behaviors. The RCMD will randomly review 10 completed MDSs weekly for 12 weeks to verify accurate coding of Hospice Services and Behaviors. . Opportunities will be corrected as identified as a result of these audits Criteria 4 The results of these audits will be presented by the Resident Care Management Director monthly for 3 months at Facility Quality Assurance Committee Meeting. The committee will make changes or recommendations as indicated. Date of Compliance: July 20, 2015	

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2. Resident #147 was admitted to the facility on 04/18/14 with diagnoses including cerebrovascular disease, cognitive deficits, altered mental status and depressive disorder.

Review of an incident and accident report dated 03/25/15 revealed a family of another resident reported they overheard Resident #147 tell Resident #56 several times to get away from him, using curse words. The family retrieved the nurse who was informed that Resident #147 had hit Resident #56 in the face with his reacher (a device used to pick up items out of reach). The investigation confirmed Resident #147 struck Resident #56.

An annual Minimum Data Set (MDS) dated 03/26/15 coded Resident #147 as being cognitively intact and having no behaviors in the previous 7 days including physical, verbal or other behaviors. As a result of the behaviors which occurred on 03/25/15 not being coded on the MDS dated 03/26/15, the area of behaviors was not triggered for a comprehensive assessment.

Interview with the MDS Director on 06/18/15 at 5:34 PM, revealed the social worker was responsible for completing the section of the MDS relating to behaviors. MDS Director stated that the hitting behavior exhibited by Resident #147 on 03/25/15 should have been coded on the MDS dated 03/26/15. She further explained that all behaviors were discussed during morning meeting involving the department heads.

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F 278	Continued From page 15 Interview with the Social Worker (SW) on 06/18/15 at 5:40 PM revealed that when she was completing a MDS, she obtained information via record review and staff, family and resident interviews. She stated the look back period was 7 days for behaviors but did not think she had to code behaviors if they were not a new issue and were already being addressed. During follow up interview on 06/18/15 at 6:15 PM, SW presented the directions for coding behaviors on the MDS that stated to use "0" (meaning no) if behaviors were previously identified but absent in the previous 7 days. SW then stated she misunderstood the directions and should have coded the behaviors noted on 03/25/15 on the MDS dated 03/26/15.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to follow the care plan interventions which addressed fall prevention for 1 of 3 sampled residents reviewed for falls. (Resident #118). The findings included: Resident #118 was admitted to the facility on 02/19/15. Her diagnoses included end stage renal disease, seizure disorder, diabetes, depression,	F 282	F 282 Services by Qualified Person/Per Care Plan Criteria 1 Corrective action was accomplished for the alleged deficient practice for Resident #118 by the Director of Nursing validating placement of bed and chair alarms and fall mats as indicated by the care plan on 6/19/15. Criteria 2	7/20/15

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F 282	Continued From page 16 left femoral fracture, joint contractures and pneumonia. The Resident Transfer Evaluation completed on 02/19/15 scored her a "19" which indicated the caregiver performed 100 percent of the task and a total mechanical lift was to be used. Review of physician orders revealed alarms were to be in the chair and/or bed since 02/28/15 and checked every 2 hours. According the Medication Administration Record (MAR) pressure alarms had been initiated to both the chair and the bed starting on 02/23/15 and signed off as being checked every 2 hours and throughout this survey. The admission Minimum Data Set (MDS) dated 03/01/15 coded her with intact cognitive skills, requiring extensive assistance with most activities of daily living skills including bed mobility, toileting, dressing, and transfers occurred only once or twice. She was also coded as being unable to stabilize herself during surface to surface transfers without human assistance. Resident #118 was coded with a history of falls with fractures prior to this admission and receiving occupational and physical therapies. Review of the nursing notes revealed on 03/07/15 at 8:00 AM, Resident #118 rolled out of bed onto the floor. She sustained a quarter size hematoma to the forehead with a 1 inch laceration in the center. Her leg was in an immobilizer already. The post fall review form dated 03/07/15 indicated a fall mat to the floor would be initiated. The form did not address if an alarm was in place and sounding at the time of the fall. Resident #118 was interviewed on 06/17/15 at 1:41 PM	F 282	Residents with care planned interventions to reduce risk of falls as at risk of being affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing and Unit Manager completed an audit of residents with care planned interventions to validate placement and function. This audit was completed on 6/18/15. Opportunities were corrected as identified. Criteria 3 The Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager (UM) will re-educate all Nursing staff on implementation of fall interventions as care planned to include the placement of alarms and fall mats. This education was completed on 6/22/15. The DON, ADON, or UM will randomly observe 10 residents weekly for 12 weeks to verify care planned interventions are in place. . Opportunities will be corrected as identified as a result of these audits Criteria 4 The results of these audits will be presented by the Director of Nursing monthly for 3 months at Facility Quality Assurance Committee Meeting. The committee will make changes or recommendations as indicated. Date of Compliance: July 20, 2015	

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and stated in March she rolled out of bed onto the floor when she got tangled in the covers. On 06/17/15 at 3:39 PM, the Assistant Director of Nursing (ADON) was interviewed and stated a fall mat was initiated on 03/07/15 when Resident #118 rolled out of bed.

A care plan was established on 03/09/15 with a goal for Resident #118 to have a reduction in potential for falls and injury which included the interventions for assurance of proper footwear, therapy, provide assistive devices in wheelchair as indicated, assist to toilet frequently and use a floor mat next to bed, with 2 floor mats if bed was not against the wall.

A Care Area Assessment (CAA) dated 03/20/15 for falls described the problem of Resident #118 being at risk for falls and having a history of falls, having weakness, unsteady gait, impaired mobility and receiving psychoactive medications. The impact of this problem was that the resident needed assistance with transfer and mobility.

A care plan for the problem of Resident #118 having had an actual fall with minor injury due to unsteady gait, psychoactive drug use and poor balance was initiated 03/20/15. The goal was to resume usual activities without further incident through the review date (06/15/15). Interventions included bed/chair alarms as ordered and floor mats beside of bed as ordered.

Review of an incident accident report indicated on 06/13/15 at 8:00 PM, Resident #118 slid out of the chair in her room. The findings indicated Resident stated she slid out of her chair while attended by a nurse aide. The resident received no apparent injury. The form did not address if

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an alarm was in place at the time of the fall. The form indicated the care plan was revised to include occupational therapy to screen regarding transfers and for 2 staff to assist.

The nurse aide sheet instructed nurse aides as to individual resident needs. Review of the sheet printed 06/17/15 revealed Resident #118 required a hoyer lift and 2 staff to assist with all transfers, required bed and chair alarms and a floor mat next to the bed and to use 2 if the bed was not against the wall.

Resident #118 was interviewed on 06/17/15 at 1:41 PM. Resident #118 stated in relation to the fall last week, she stated staff came in with a lift to transfer her to bed but she was not ready. Later when she was ready for bed, one staff, described as a new nurse aide and name unknown, entered the room without the hoyer lift and stated that she would just transfer the resident herself. Resident #118 stated that she must have been too heavy for the nurse aide as the nurse aide tried to return her to the wheelchair, sat her on the edge of the seat and Resident #118 slid off the wheelchair onto the floor. Resident #118 stated she was usually transferred via hoyer lift.

Interview with the ADON on 06/17/15 at 3:39 PM revealed that when a fall occurred, nursing staff completed the incident report and a post fall review form. An investigation was to include statements from the resident and witnesses and staff on duty surrounding the time of the incident. Every morning at morning meeting, the falls, reports and interventions were reviewed.

On 06/18/15 at 11:55 AM the physical therapy

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aide (PTA) stated therapy was working with Resident #118 to increase transfer abilities with the use of a transfer board and pivot transfers. PTA stated Resident #118 was inconsistent with her pivot transfers and had not been released to the floor nurse aides to transfer any other way than the use of a hoyer lift and 2 staff assist.

Interview with NA #1 on 06/18/15 at 3:00 PM revealed she was a new nurse aide and received 1 to 2 weeks or orientation working with other nurse aides. She stated she picked up a nurse aide sheet that informed staff of resident's individual needs each day of work, as instructed during orientation. She stated that earlier in the day of 06/13/15, she and NA #2 transferred Resident #118 using the hoyer lift. Later in the day, Resident #118 did not want to use the lift to return to bed. NA #1 stated she proceeded to transfer the resident to bed via gait belt, and when she realized she could not do it herself, she lowered Resident #118 to the floor. NA #1 stated she knew the resident required a hoyer lift and did not report the resident's refusals to use the hoyer lift to the nurse on duty. She further stated the nurse on the evening of 06/13/15 counseled her on following the nurse aide sheets as did the DON after this incident.

Observations revealed Resident #118 was in bed, which was not against the wall and open floor space observed on both sides of the bed with no floor mats in place on 06/16/15 at 8:21 AM, 9:18 AM and 9:36 AM; and on 06/18/15 at 7:41 AM, 8:52 AM, at 8:56 AM, at 9:24 AM, at 12:05 PM, and at 12:46 PM.

Observations revealed Resident #118 was in a high back wheelchair with no alarm on 06/17/15

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at 1:41 PM while in her room, at 3:52 PM and at 4:10 PM while out on the front porch; and on 06/18/15 at 2:33 PM after being transferred to the wheelchair and taken outside to the porch area.

Interview with Resident #118 on 06/18/15 at 8:56 AM revealed she did not recall having an alarm on the wheelchair the day of the fall of 06/13/15. She was unsure she ever had an alarm in the wheelchair. On 06/18/15 at 12:46 during follow up interview, Resident #118 stated she did not recall ever having floor mats on the floor of either side of bed.

NA #2 was interviewed on 06/18/15 at 12:46 PM about fall mats for Resident #118. NA #2 checked the nurse aide sheets in her pocket for the information and discovered she did not have the sheet that included information about Resident #118. She then went to the nursing station and looked at a sheet which included this resident's information. She stated she knew nothing about the floor mats.

Following a transfer from bed to wheelchair completed by NA #1 and NA #3, NA #1 was interviewed on 06/18/15 at 2:37 PM. NA #1 stated she did not refer to the nurse aide sheets about the fall mat or alarms. NA #3 joined the interview and stated she did not know about the need for alarms and stated she was not assigned to Resident #118 this date. Neither could recall any floor mats being used for Resident #118.

Interview with NA #2 on 06/18/15 at 3:00 PM revealed she could not recall the use of floor mats or alarm in the wheelchair for Resident #118.

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F 282	Continued From page 21 Interview with the DON on 06/18/15 at 5:04 PM revealed after a fall, the reports and interventions and information surrounding the falls were reviewed in morning meeting and the nurse aide sheets were updated with interventions. Her expectation was for nurse aides to follow the nurse aide assignment sheets and the care plans.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, record review and staff interviews, the facility failed to implement care planned interventions to prevent falls and thoroughly investigate the circumstances surrounding a fall for 1 of 3 sampled residents reviewed for falls. (Resident #118). The findings included: Resident #118 was admitted to the facility on 02/19/15. Her diagnoses included end stage renal disease, seizure disorder, depression, left femoral fracture, joint contractures and pneumonia.	F 323	F 323 Free of Accident/Hazards/Supervision/Devices Criteria 1 Corrective action was accomplished for the alleged deficient practice for Resident #118 by the Director of Nursing validating placement of bed and chair alarms and fall mats as indicated by the care plan on 6/19/15. Criteria 2 Residents with care planned interventions to reduce risk of falls as at risk of being affected by this alleged deficient practice. The Director of Nursing, Assistant	7/20/15

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F 323	Continued From page 22 The Resident Transfer Evaluation completed on 02/19/15 scored her a "19" which indicated the caregiver performed 100 percent of the task and a total mechanical lift was to be used. Resident #118 was hospitalized on 02/20/15 and reentered the facility on 02/23/15. Review of physician orders revealed alarms were to be in the chair and/or bed since 02/28/15 and checked every 2 hours. According the Medication Administration Record (MAR) pressure alarms had been initiated to both the chair and the bed starting on 02/23/15 and signed off as being checked every 2 hours and throughout this survey. The admission Minimum Data Set (MDS) dated 03/01/15 coded her with intact cognitive skills, requiring extensive assistance with most activities of daily living skills including bed mobility, toileting, dressing, and transfers occurred only once or twice. She was also coded with unstageable pressure ulcers and being unable to stabilize herself during surface to surface transfers without human assistance. Resident #118 was coded with a history of falls with fractures prior to this admission and receiving occupational and physical therapies. Review of the nursing notes revealed on 03/07/15 at 8:00 AM, Resident #118 rolled out of bed onto the floor. She sustained a quarter size hematoma to the forehead with a 1 inch laceration in the center. Her leg was in an immobilizer already. The post fall review form dated 03/07/15 indicated a fall mat to the floor would be initiated. Resident #118 was interviewed on 06/17/15 at 1:41 PM and stated in March she rolled out of	F 323	Director of Nursing and Unit Manager completed an audit of residents with care planned interventions to validate placement and function. The Director of Nursing and Administrator completed an audit of investigations following a resident fall that occurred during the last 30 days to validate accurate and complete investigation. These audits were completed on 6/18/15. Opportunities were corrected as identified. Criteria 3 The Division Director of Clinical Services re-educated the Director of Nursing and Administrator on accurate and complete investigations on 6/24/15. The Director of Nursing (DON), Assistant Director of Nursing (ADON) or Unit Manager (UM) will re-educate all Nursing staff on implementation of fall interventions as care planned to include the placement of alarms and fall mats. This education was completed on 6/22/15. The DON, ADON, or UM will randomly observe 10 residents weekly for 12 weeks to verify care planned interventions are in place. . Opportunities will be corrected as identified as a result of these audits Criteria 4 The results of these audits will be presented by the Director of Nursing monthly for 3 months at Facility Quality Assurance Committee Meeting. The committee will make changes or	

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F 323	Continued From page 23 bed onto the floor when she got tangled in the covers. On 06/17/15 at 3:39 PM, the Assistant Director of Nursing (ADON) was interviewed and stated a fall mat was initiated on 03/07/15 when Resident #118 rolled out of bed. A care plan was established on 03/09/15 with a goal for Resident #118 to have a reduction in potential for falls and injury which included the interventions for assurance of proper footwear, therapy, provide assistive devices in wheelchair as indicated, assist to toilet frequently and use a floor mat next to bed, with 2 floor mats if bed was not against the wall. Resident #118 was hospitalized on 03/10/15 and reentered the facility on 03/13/15. A Care Area Assessment (CAA) dated 03/20/15 for falls described the problem of Resident #118 being at risk for falls and having a history of falls, having weakness, unsteady gait, impaired mobility and receiving psychoactive medications. The impact of this problem was that the resident needed assistance with transfer and mobility. A care plan for the problem of Resident #118 having had an actual fall with minor injury due to unsteady gait, psychoactive drug use and poor balance was initiated 03/20/15. The goal was to resume usual activities without further incident through the review date (06/15/15). Interventions included bed/chair alarms as ordered and floor mats beside of bed as ordered. Review of an incident accident report indicated on 06/13/15 at 8:00 PM, Resident #118 slid out of the chair in her room. The findings indicated Resident stated she slid out of her chair while	F 323	recommendations as indicated. Date of Compliance: July 20, 2015	

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attended by a nurse aide. The form included the question "Was incident/accident witnessed?" which was checked "NO" and the space for the name of the witness was left blank. The resident received no apparent injury. The form indicated the care plan was revised to include occupational therapy to screen regarding transfers and for 2 staff to assist.

There were 2 Interdisciplinary post fall reviews completed for this 06/13/15 fall as follows:
a. A handwritten post fall review signed as completed on 06/15/15 noted this fall was unwitnessed, the resident stated she slid out of her wheelchair and that the interdisciplinary team noted plans were for 2 staff to assist the resident with all transfers and occupational therapy (OT) was to continue treatment of resident for positioning.
b. A computerized post fall review signed as completed on 06/16/15 by Nurse #4 noted this was a witnessed fall that occurred during an assisted transfer, and the intervention recommendation was staff education and hoyer lift with 2 staff assistants with care plan revisions.
On 06/18/15 at 11:25 PM, the DON, ADON and Nurse #4 were interviewed. The ADON stated that she could not locate a post fall review for the incident on 06/13/15 so she completed the computerized form under Nurse #4's name as the computer was up and running under Nurse #4's name. With the survey team entering this week, ADON forgot she had started one in the computer and did another one on paper. ADON stated she thought the fall was unwitnessed. Neither the DON or the ADON interviewed either nurse aide on the hall and when the ADON interviewed the resident, she stated she slid out of the wheelchair and no further questions were asked of the

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resident.

The nurse aide sheet instructed nurse aides as to individual resident needs. Review of the sheet printed 06/17/15 revealed Resident #118 required a hoyer lift and 2 staff to assist with all transfers, required bed and chair alarms and a floor mat next to the bed and to use 2 if the bed was not against the wall.

Resident #118 was interviewed on 06/17/15 at 1:41 PM. Resident #118 stated in relation to the fall last week, she stated staff came in with a lift to transfer her to bed but she was not ready. Later when she was ready for bed, one staff, described as a new nurse aide and name unknown, entered the room without the hoyer lift and stated that she would just transfer the resident herself. Resident #118 stated that she must have been too heavy for the nurse aide as the nurse aide tried to return her to the wheelchair, sat her on the edge of the seat and Resident #118 slid off the wheelchair onto the floor. Resident #118 stated she was usually transferred via hoyer lift.

Interview with the ADON on 06/17/15 at 3:39 PM revealed that when a fall occurred, nursing staff completed the incident report and a post fall review form. An investigation was to include statements from the resident and witnesses and staff on duty surrounding the time of the incident. Every morning at morning meeting, the falls, reports and interventions were reviewed. ADON stated she spoke to the nurse working on 06/13/15 who reported the fall was unwitnessed. She did not speak to any nurse aide working during that time for additional information. When she asked Resident #118 what happened, the

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resident told her she slid out of the chair. The ADON stated she did not ask the resident any further questions.

On 06/17/15 at 4:33 PM an interview was conducted with Nurse Aide (NA) #2 who was working on Resident #118's hall assignment the evening of 06/13/15. NA #2 stated she was not assigned to Resident #118 and another new nurse aide was working with her. She stated that she looked in the room as NA #1 was caring for Resident #118 and asked if she needed any help. NA #1 stated no and NA #2 then left. NA #2 stated she did not know what care was being provided at that time. NA #2 stated Resident #118 told her she tried to walk with the help of the other nurse aide and ended up falling.

On 06/18/15 at 11:55 AM the Rehab Director stated therapy was working with Resident #118 to increase transfer abilities with the use of a transfer board and pivot transfers. Rehab Director stated Resident #118 was inconsistent with her pivot transfers and had not been released to the floor nurse aides to transfer any other way than the use of a hoyer lift and 2 staff assist.

Interview with NA #1 on 06/18/15 at 3:00 PM revealed she was a new nurse aide and received 1 to 2 weeks or orientation working with other nurse aides. She stated she picked up a nurse aide sheet that informed staff of resident's individual needs each day of work, as instructed during orientation. She stated that earlier in the day of 06/13/15, she and NA #2 transferred Resident #118 using the hoyer lift. Later in the day, Resident #118 did not want to use the lift to return to bed. NA #1 stated she proceeded to

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transfer the resident to bed via gait belt, and when she realized she could not do it herself, she lowered Resident #118 to the floor. NA #1 stated she knew the resident required a hoyer lift and did not report the resident's refusals to use the hoyer lift to the nurse on duty. She further stated the nurse on the evening of 06/13/15 counseled her on following the nurse aide sheets as did the DON after this incident.

Nurse #1, who worked the evening of 06/13/15 and who completed the incident report was no longer employed and attempts to reach him by phone were unsuccessful as his phone was no longer inservice.

Observations revealed Resident #118 was in bed, which was not against the wall and open floor space observed on both sides of the bed with no floor mats in place on 06/16/15 at 8:21 AM, 9:18 AM and 9:36 AM; and on 06/18/15 at 7:41 AM, 8:52 AM, at 8:56 AM, at 9:24 AM, at 12:05 PM, and at 12:46 PM.

Observations revealed Resident #118 was in a high back wheelchair with no alarm on 06/17/15 at 1:41 PM while in her room, at 3:52 PM and at 4:10 PM while out on the front porch; and on 06/18/15 at 2:33 PM after being transferred to the wheelchair and taken outside to the porch area.

Interview with Resident #118 on 06/18/15 at 8:56 AM revealed she did not recall having an alarm on the wheelchair the day of the fall of 06/13/15. She was unsure she ever had an alarm in the wheelchair. On 06/18/15 at 12:46 during follow up interview, Resident #118 stated she did not recall ever having floor mats on the floor of either side of bed.

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F 323	Continued From page 28 NA #2 was interviewed on 06/18/15 at 12:46 PM about fall mats for Resident #118. NA #2 checked the nurse aide sheets in her pocket for the information and discovered she did not have the sheet that included information about Resident #118. She then went to the nursing station and looked at a sheet which included this resident's information. She stated she knew nothing about the floor mats. Following a transfer from bed to wheelchair completed by NA #1 and NA #3, NA #1 was interviewed on 06/18/15 at 2:37 PM. NA #1 stated she did not refer to the nurse aide sheets about the fall mat or alarms. NA #3 joined the interview and stated she did not know about the need for alarms and stated she was not assigned to Resident #118 this date. Neither could recall any floor mats being used for Resident #118. Interview with NA #2 on 06/18/15 at 3:00 PM revealed she could not recall the use of floor mats or alarm in the wheelchair for Resident #118. Interview with the DON on 06/18/15 at 5:04 PM revealed after a fall, the reports and interventions and information surrounding the falls were reviewed in morning meeting and the nurse aide sheets were updated with interventions. Her expectation was for nurse aides to follow the nurse aide assignment sheets and the care plans.	F 323		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest	F 469		7/17/15

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F 469	Continued From page 29 control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to ensure that all fly reduction measures were working to prevent fly activity in resident rooms and common areas for 2 of 2 sampled residents (Resident #68 and #14) and the facility failed to implement fly prevention measures on 2 of 4 Halls. The findings included: 1. Resident #68 was admitted to the facility on 05/9/14. The most recent Minimum Data Set (MDS) dated 04/01/15 specified the resident had no impaired cognition. On 06/16/15 at 9:26 AM Resident #68 was interviewed in her room. Observations were made of the resident ' s room that revealed a fly swatter on the bed. Resident #68 was asked about the conditions of her room and she reported that she had difficulty with fly activity and kept a fly swatter. The Resident stated that she didn't want to complain and wasn't sure if the facility could do anything to prevent flies. During the observation and interview there was a fly buzzing around the resident's room. The fly was noted to land on her personal belongings. On 06/17/15 at 1:50 PM the Maintenance Director was interviewed and reported that the facility had monthly pest control prevention services. He explained that the facility had several methods for reducing fly activity in the facility that included light traps and fly fans. He added that the monthly pest service changed the fly traps inside	F 469	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F 469 Maintains Effective Pest Control Program Criteria 1 Repairs made to fly fans on two courtyard doors on 6/16/15 and all other fly fans were checked on 6/16/15 to verify appropriate function. On 6/18/15 Pest Control Prevention measures (fly lights) were installed on 300/400 hall corridors by the facility¿s contracted pest control representative. Criteria 2 All residents of the facility have the potential to be affected by this alleged deficient practice. Criteria 3 Both the fly fans and fly lights throughout the facility will be monitored for appropriate functioning 5 days per week for 12 weeks by the Maintenance Director	

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F 469	Continued From page 30 the lights monthly but the facility was responsible for maintaining the fly fans. The Maintenance Director reported that he wasn't aware of complaints of fly activity in the facility. Observations were made of the facility's courtyard that had two doors leading from the facility common areas into the interior courtyard. Above each exterior door leading to the courtyard was a fly fan (an electric fan that emitted large amounts of air when the door was opened to prevent flies from entering the building). The Maintenance Director was present for the observation that when the doors to the courtyard were opened, the fly fans did not turn on. The Maintenance Director was interviewed and reported that he was not aware fans were not working and wasn't sure if they had been turned off or had malfunctioned. He stated that he expected the fans to be on but added that he didn't routinely check them. 2. Resident #14 was admitted to the facility on 01/29/15. The most recent Minimum Data Set (MDS) dated 04/27/15 specified the resident had short term memory impairment. On 06/16/15 at 8:34 AM Resident #14 was in his room eating breakfast. Observations revealed the resident was eating breakfast and swatting at a fly that was attempting to land in his food. Resident #14 was interviewed and reported that "every day that fly is in here and it's driving me crazy." On 06/17/15 at 1:50 PM the Maintenance Director was interviewed and reported that the facility had pest control prevention services that came monthly. He explained that the facility had several methods for reducing fly activity in the facility that included light traps and fly fans. He added that the monthly pest service changed the fly traps inside the lights monthly but the facility	F 469	and recorded in a monitoring log. Criteria 4 Following the completion of the 12 weeks these devices will be monitored and documented monthly by the Maintenance Director. This documentation will be presented monthly at Facility Quality Assurance Committee Meeting.	

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maintained the fly fans. The Maintenance Director reported that he wasn't aware of complaints of fly activity in the facility.
Observations were made of the facility's courtyard that had two entrances. Above each exterior door leading to the courtyard was a fly fan (an electric fan that emitted large amounts of air when the door was opened to prevent flies from entering the building). The Maintenance Director was present for the observation that when the doors to the courtyard were opened, the fly fans did not turn on. The Maintenance Director was interviewed and reported that he was not aware fans were not working and wasn't sure if they had been turned off or had malfunctioned. He stated that he expected the fans to be on but added that he didn't routinely check them.
3. On 06/18/15 at 10:00 AM a tour of 300 and 400 Hall was made that revealed the only fly prevention measure in place was a fly swatter at the nurses' station. During the observation, a fly was swarming around the nurses' station. During the observation, Nurse #5 was present and interviewed and reported that fly activity was a problem and that a fly swatter was kept for use.
On 06/18/15 at 10:10 AM the medication technician was observed attempting to pour nutritional supplements into plastic cups, she was noted to swat at a fly attempting to land where she was pouring a resident's nutritional supplement. The medication technician was interviewed and stated that every time she worked on the 300 and 400 Halls flies were a problem.
On 06/18/15 at 2:30 PM the pest control service representative was present in the facility and interviewed. He reported that he was aware that the facility did not have service contract for fly prevention measures on the 300 or 400 Halls. He

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F 469	Continued From page 32 added that he was unaware of issues with fly activity on those halls. He stated that during the summer months he used a dry spray to detract flies but that the facility was due to have the spray. On 06/18/15 at 4:50 PM the Administrator was interviewed and reported that he wasn't aware that the 300 or 400 Halls did not have fly prevention measures similar to the other halls. He added that he was not made aware of concerns with fly activity on those halls. He added that he would install fly lights to reduce fly activity on those halls.	F 469		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		7/20/15

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F 520	Continued From page 33 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facilities Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place in April of 2014. This was for two recited deficiencies which were originally cited in March of 2014 on a recertification survey and on the current recertification survey. The deficiencies were in the areas of accident prevention and completing care area assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: a. F 272: Comprehensive Assessments: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes, contributing factors, and risk factors for 2 of 10 sampled residents reviewed for the most recent comprehensive Minimum Data Set (Residents #135, #118). The facility was recited for F 272 for failing to complete care area assessments for 2 of 10 sampled residents. F 272 was originally cited for failing to complete care area assessments for 6 of 12 sampled residents during a recertification survey in March of 2014.	F 520	F 520 QAA Committee Members/Meet Quarterly/Plans Criteria 1 Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 7/15/15 to discuss the outcomes of the annual survey and repeat citations of F278 related to descriptive Care Area Assessments and F323 related to implementation of interventions to prevent falls. The Interdisciplinary Department Head Team reviewed the previous plan of correction related to resident CAAs and falls interventions. Criteria 2 Residents requiring Care Area Assessments with MDS completion and residents requiring interventions to prevent falls have the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing, Resident Care Management Director, and Unit Manager have completed an audit of required CAAs to ensure accurate description of the resident according to the RAI manual and an audit to validate implementation of care planned falls interventions. This audit will be completed by 7/16/15. Criteria 3	

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F 520	Continued From page 34 b. F323: Free of Accidents Hazards/supervision/devices: Based on observations, resident interviews, record review and staff interviews, the facility failed to implement care planned interventions to prevent falls and thoroughly investigate the circumstances surrounding a fall for 1 of 3 sampled residents reviewed for falls (Resident #118). The facility was recited for F 323 for failing to implement physician ordered, care planned interventions to prevent falls and fall related injuries which included floor mats at Resident #118's bedside and alarms being utilized in Resident #118's chair and bed. F 323 was originally cited for failing to utilize a chair alarm for 1 of 3 sampled residents in March of 2014. During an interview on 06/18/15 at 7:33 PM the Administrator reported falls were targeted for reduction through a performance review process. The Administrator added a plan similar to a generic plan of correction would be developed based on the information obtained through the performance review process. The Administrator verbalized if goals for fall prevention were not being meet approaches and goals would be revised. The Administrator reported the current Quality Assurance Committee monitored residents with falls to assure staff were following the care planned interventions and the Nurse Aid care guide adding this particular piece was missed during monitoring. The Administrator indicated the deficiencies related to the CAAs were due to the different disciplines completing them. The Administrator verbalized the facility should have some oversight concerning development of the CAAs.	F 520	The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F278 Assessment Accuracy and F323 Supervision to prevent Accidents. This education was completed by 7/15/15. The Administrator will hold a weekly Ad Hoc QAPI committee meeting to review F278 Assessment Accuracy and F323 Supervision to prevent Accidents to ensure all regulatory aspects are addressed and in compliance. Opportunities will be corrected as identified. Criteria 4 Measures to ensure that corrections are achieved & sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 7/20/15	