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	345312	A. BUILDING _____ B. WING _____	07/17/2015

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BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

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F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, the facility failed to honor preferences for 1 of 4 residents related to showers (Resident #32). Findings included: Resident #32 was admitted to the facility on 12/18/12. Diagnoses included muscle disuse atrophy. A quarterly Minimum Data Set (MDS) dated 06/09/15 indicated Resident #32 was cognitively intact, did not reject care, and required total assistance of one staff member with personal hygiene and bathing. The MDS further indicated Resident #32 had range of motion limitations to both upper extremities and both lower extremities. Review of the Resident #32's care plan revealed a problem area dated 07/15/15 which addressed a deficit with activities of daily living. An intervention included assisting the resident with a shower twice a week and as needed. An interview was conducted with Resident #32 on 07/14/15 at 10:25 AM. He stated he received two showers per week. He explained he would like to have a shower every day but would be happy with three showers per week. Resident #32 further	F 242	F242 SS=D Criteria #1- Resident #32 had preference sheet completed on 7/08/2015 prior to survey. Resident's individual care plan was immediately updated as well as resident's shower schedule to reflect his shower preference of 3 times per week. RCS care cards updated to reflect the change. Criteria #2- 100% audit completed for all current residents regarding shower preference and any changes the resident would prefer. Care plans and care cards updated to reflect preferences. Criteria #3- Upon admission the resident and or resident's family will be asked shower preferences and care card/care plan will be updated by admitting nurse. All nursing staff and Admission coordinator will be	8/14/15

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

Electronically Signed | 08/10/2015

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F 242	Continued From page 1 stated he had let the facility know he wanted more showers a couple of weeks ago but had yet to receive more than two per week. Review of the shower schedule for Resident #32's hall revealed each room and bed was scheduled for two showers per week on either day shift or evening shift. Review of the care sheet for Resident #32's hall revealed he was scheduled for two showers per week on day shift. Review of Resident #32's shower documentation revealed the resident received two showers per week for the months of May, June, and through the dates of the survey in July. Review of Resident #32's Resident Preferences Evaluation, not dated, revealed he preferred a shower in the morning three times per week. An interview was conducted with Nurse Aides (NAs) #2 and #3 on 07/15/15 at 9:32 AM. They stated they knew which showers to give based on their Care Sheets. The NAs further explained each resident received two showers per week, based on which room and bed the resident was in. They also stated the care sheets were updated daily. An interview was conducted with Nurse #1 on 07/15/15 at 4: 20 PM. She stated each resident was told on admission when his or her shower was assigned. The nurse explained showers were scheduled according to which room and bed the resident was in. She further stated the shower schedule could be changed if the resident objected. An interview was conducted with the Director of Nursing (DON) on 07/16/15 at 10:55 AM. She stated residents were assigned showers based on room and bed at the time. The DON explained the facility had recently been completing the Resident Preferences Evaluation	F 242	educated on preferences and adhering to resident's bathing preference schedule by Director of Nursing or Unit Manager. The Director of Nursing or Unit Manager will randomly interview 5 residents weekly for 4 weeks and then 5 residents monthly for 3 months to verify bathing preferences are being provided. Criteria #4- Any preferences noted during interviews will be updated immediately by the interviewer. The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting for 3 months. The committee will evaluate and make further recommendations as indicated.	

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F 242	Continued From page 2 and was in the process of updating shower schedules and care plans with resident preferences as the Evaluations were completed.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to replace stained and cracked caulking at the base of toilets and maintain the veneer of resident bedroom doors and a fire door on 1 of 5 resident hallways (300 hallway). The facility also failed to maintain an environment free of odors in a resident room on 1 of 5 resident hallways (300 hallway). The findings included: 1. Observations during the survey revealed the following bathrooms were not in good repair: a. Observations of the bathroom for room 306 on 07/13/15 at 3:05 PM revealed the caulking at the base of the toilet was stained brown and cracked. On 07/17/15 at 3:40 PM the Maintenance Supervisor observed the bathroom for room 306 and confirmed the caulking at the base of the toilet would need to be replaced. The Maintenance Supervisor stated he was not aware of the condition of the caulking at the base of the toilet in room 306.	F 253	F253 SS=D Criteria 1- a.The facility failed to replace stained and cracked caulking at the base of toilets and maintain the veneer of resident room doors and a fire door located on 1 of 5 resident hallways (300 hallways). The facility also failed to maintain an environment free of odors in a resident room on 1 of 5 hallways (300 hallways). b. On 07/13/2015 room 306 revealed caulking at the base of the toilet was stained brown and cracked. On 08/10/2015 tile, toilet seal and caulking were replaced. The odor appears to have been eliminated. c. On 07/17/2015 room 312 revealed the caulking at the base of the toilet was stained brown and cracked. d. On 08/04/2015 toilet in room 312 was recaulked. e. On 07/13/2015 revealed all 13 bedroom doors and 2 fire doors had gouged veneer approximately 8 inches from the bottom of	8/14/15

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F 253	Continued From page 3 b. Observations of the bathroom for room 305 on 07/14/15 at 9:40 AM revealed the caulking at the base of the toilet was stained brown and cracked. On 07/17/15 at 3:46 PM the Maintenance Supervisor observed the bathroom for room 305 and confirmed the caulking at the base of the toilet would need to be replaced. The Maintenance Supervisor stated he was not aware of the condition of the caulking at the base of the toilet in room 305. c. Observations of the bathroom for room 312 on 07/17/15 at 10:18 AM revealed the caulking at the base of the toilet was stained brown and cracked. On 07/17/15 at 3:51 PM the Maintenance Supervisor observed the bathroom for room 312 and confirmed the caulking at the base of the toilet would need to be replaced. The Maintenance Supervisor stated he was not aware of the condition of the caulking at the base of the toilet in room 312. 2. Observations of the 300 hallway on 07/13/15 at 3:05 PM revealed all 13 bedroom doors and 2 fire doors had gouged veneer approximately 8 inches from the bottom of the door which extended across the entire width of the door. During an interview on 07/17/15 at 3:34 PM the Maintenance Supervisor stated staff notified him verbally of needed repairs when he was in the building and there were also slips they could fill out and place in his box which he checked several times a day. The interview further revealed the Administrator and the Maintenance Supervisor had gone room to room in the facility	F 253	the door. On 08/07/2015 kick plates were installed on 13 bedroom doors and 2 fire doors located on the 300 hallway. Criteria 2- Facility residents have the potential to be affected by this alleged deficient practice. The Maintenance Director and the Housekeeping Director will conduct an audit of resident¿s rooms, bathrooms and hallways to ensure the master repair list is complete and up-to-date. The Maintenance Director and the Housekeeping will establish a timeline of completion of items on the master list. The facility Ambassadors (team members who visit with residents routinely to identify concerns/needs) will observe and inspect 10 rooms weekly for 4 weeks and then 10 rooms every other week for two months to include observation of walls, odors and cleanliness of rooms/bathrooms. Criteria 3- Measures put into place to ensure the alleged deficient practice does not reoccur include: The Maintenance Director, Administrator will conduct re-education for all staff on, to be completed by August 13, 2015, regarding observation of furnishings, walls and cleanliness of rooms and bathrooms and appropriate process for reporting needed repairs. The facility¿s Ambassadors (team members who visit with residents routinely to identify concerns/needs) will observe and inspect	

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F 253	Continued From page 4 and created a master list of room repairs but did not have a timeline for the completion of the repairs. The Maintenance Supervisor further stated they typically waited until they could move the residents for a few days or a room was empty to complete repairs. At 3:52 PM the Maintenance Supervisor observed the bedroom doors and emergency doors on the 300 hallway and agreed the gouged veneer needed to be repaired or covered with a kick plate. An interview was conducted with the Administrator on 07/17/15 at 3:59 PM after observations of the bedroom doors and emergency doors on the 300 hallway. The Administrator agreed the doors needed to be repaired or covered with a kick plate. The Administrator stated the doors on the 300 hallway were included in the mater list of room repairs but there was no timeline for the completion of the repairs. 3. Observations of the 300 hallway on 07/13/15 at 3:05 PM revealed a faint urine odor in the hall just outside of room 306. The urine odor was noted also in the resident's room and was strongest in the bathroom. The residents were not in the room at the time of the observation. There was no urine observed on the bathroom floor or in the toilet. Subsequent observations were as follows: - On 07/14/15 at 10:16 AM a faint urine odor was noted in the hall just outside of room 306. The urine odor was also noted in the resident's room and was strongest in the bathroom. There was no urine observed on the bathroom floor or in the toilet - On 07/15/15 at 9:00 AM and 2:11 PM a faint urine odor was noted in the hall just outside of	F 253	10 residents¿ rooms weekly for 4 weeks and then 10 resident¿s rooms monthly for 3 months to include observation of walls, cleanliness of bathroom/rooms, and observation of condition of furnishings. Criteria 4- The Administrator, Maintenance Director and Housekeeping Manager will review data obtained during facility audits and analyze data and report any trends to the QAPI meeting monthly for 3 months. The committee will evaluate the effectiveness of the plan, and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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F 253	Continued From page 5	F 253		

room 306. The urine odor was also noted in the resident's room and was strongest in the bathroom. There was no urine observed on the bathroom floor or in the toilet.
- On 07/16/15 at 8:55 AM and 10:10 AM a faint urine odor was noted in the hall just outside of room 306. The urine odor was also noted in the resident's room and was strongest in the bathroom. The housekeeper was preparing to clean room 306 at the time of the observation.
- On 07/16/15 at 3:43 PM a faint urine odor was noted in the hall just outside of room 306. The urine odor was also noted in the resident's room and was strongest in the bathroom. There was no urine observed on the bathroom floor or in the toilet.
- On 07/17/15 at 9:30 AM a faint urine odor was noted in the hall just outside of room 306. The urine odor was also noted in the resident's room and was strongest in the bathroom. There was no urine observed on the bathroom floor or in the toilet.

An interview was conducted with Housekeeper #1 on 07/16/15 at 10:10 AM as she prepared to clean room 306. Housekeeper #1 stated the toilet was cleaned daily using a disinfectant spray and the bathroom floor was also mopped daily.

On 07/17/15 at 3:40 PM the Maintenance Supervisor and Housekeeping Supervisor were accompanied to room 306 and confirmed there was a strong urine odor in the room and bathroom. The Housekeeping Supervisor stated he was not aware of the urine odor in room 306 prior to this observation. The Maintenance Supervisor and Housekeeping Supervisor stated they did not know what was causing the odor but they would work together on a solution.

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F 253	Continued From page 6 An interview was conducted with the Administrator on 07/17/15 at 3:59 PM. The Administrator observed room 306 and agreed it was not homelike and they would need to identify the source of the odor and find a solution.	F 253		
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. 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.	F 278		8/14/15

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F 278	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to code an admission Minimum Data Set (MDS) correctly to reflect a resident had been evaluated by Level II PASSR (Preadmission Screening and Review) for 1 of 1 resident sampled for PASSR review (Resident #178). The findings included: Resident #178 was admitted on 05/06/15 with diagnoses including paranoid schizophrenia. Review of a document which included Resident #178's PASSR history noted his Level II PASSR number was 2015117203F. The document further revealed the start date was 04/27/15 and the end date was 06/24/15. The admission MDS dated 05/13/15 indicated Resident #178 had not been evaluated by Level II PASSR to determine if he had serious mental illness. An interview was conducted with MDS Nurse #1 on 07/16/15 at 3:10 PM. MDS Nurse #1 stated she did not know Resident #178 met the Level II PASSR conditions when he was first admitted to the facility but the Admissions Coordinator told her when he was readmitted on 06/03/15. MDS Nurse #1 stated a resident should be coded for Level II PASSR on the MDS if the screening determined the resident had a serious mental illness. During an interview on 07/16/15 at 3:30 PM the Admissions Coordinator stated she usually informed the Social Worker and the MDS nurses	F 278	F278 SS=D Criteria #1- Corrective action has been accomplished for the alleged deficient practice with regard to resident # 178. The assessment was modified to show Level 2 PASSR on 7/22/15. Criteria #2- Facility residents who have a Level 2 PASSR have the potential to be affected by the same alleged deficient practice. The admissions director completed 100% audit of currently admitted residents to ensure MDS was aware of all Level 2 PASSR to ensure proper coding. Only 1 Level 2 was noted resident #178, the MDS was corrected on 7/22/15. Criteria #3- Measures put into place to ensure that the alleged deficient practice does not reoccur include: The District Director of Clinical Services will conducted in-service/re-education for the Resident Care Management Director, MDS Coordinator, Admissions Director , and Social Services Director on August 5, 2015,regarding MDS Accuracy and proper coding for all diagnosis to include what constitutes level II PASSAR as described in the RAI manual. The Resident Care	

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F 278	Continued From page 8 when a resident was admitted with a Level II PASSR. The Admissions Coordinator further stated she knew Resident #178 met the Level II PASSR conditions on preadmission but did not think she had informed the MDS nurses.	F 278	Management Director will audit 10 assessments per month for 3 months to ensure accurate coding of PASSR type. Criteria #4- The Resident Care Management Director will review data obtained during assessment audits, analyze the data and report patterns/ trend to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan. Committee will evaluate findings and make further adjustments and recommendations as indicated. Compliance date 8/14/2015	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		8/14/15

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F 279	Continued From page 9 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews, the facility failed to develop a comprehensive care plan for 1 of 3 residents reviewed for range of motion (Resident #32). Findings included: Resident #32 was admitted to the facility on 12/18/12. Diagnoses included muscle disuse atrophy. A quarterly Minimum Data Set (MDS) dated 06/09/15 indicated Resident #32 was cognitively intact and had range of motion limitations to both upper extremities and both lower extremities. The MDS further indicated the resident received no restorative nursing services. During an interview with Resident #32 on 07/14/15 at 10:25 AM, both of the resident ' s hands and arms were observed with contractures and no splint in place, and the left hand and arm were more contracted than the right. Resident #32 stated he only had use of his right index finger and some range of motion in his right arm. Review of the Resident #32's care plan dated 07/15/15 revealed no problem area addressing the resident ' s limited range of motion or interventions to maintain or improve the current level of functioning. An interview was conducted with the Therapy	F 279	F279 SS=D Criteria 1- Resident #32 was evaluated by therapy and his care plan was updated to reflect his limitations and interventions to address his needs. Criteria 2- Residents with decreased range of motion have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director and/or Director of Nursing has completed an audit of current residents care plans to identify that care plans reflect the residents¿ assessments and care needs related to range of motion limitations. Criteria 3- The Director of Nursing or Rehab Program Manager will conduct education for the Resident Care Management Director and MDS nurses on ensuring care plans address residents¿ limitations and include interventions to maintain or improve the resident¿s current level of	

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F 279	Continued From page 10 Director on 07/16/15 at 2:59 PM. She stated occupational therapy had worked with Resident #32 to improve the range of motion in the resident's hand through a variety of means and was discharged in March 2015. The Therapy Director further stated when residents were discharged from therapy, the expectation was that nursing would continue providing range of motion exercises. An interview was conducted with Nurse Aide (NA) #1 on 07/16/15 at 4:05 PM. NA #1 stated Resident #32 was not receiving range of motion exercises. She further explained she was unaware of any recommendations from therapy regarding continued range of motion exercises. An interview was conducted with NA #4 on 07/16/15 at 4:15 PM. He stated the NAs typically did not provide range of motion exercises because daily care, such as dressing and showers, provided range of motion for the residents. An interview was conducted with the Director of Nursing (DON) on 07/17/15 at 11:57 AM. The DON explained Resident #32 should have been receiving some kind of regular exercises to prevent contractures and a decline in functioning. She also stated the NAs were encouraged to do range of motion exercises with residents but that was not happening.	F 279	functioning. The Director of Nursing or Unit Managers will audit 4 care plans weekly for 4 weeks and then 4 monthly for 3 months to ensure range of motion limitations and individualized interventions are reflected in care plans. Criteria 4- The results of the audits will be brought monthly to the Quality Assurance Performance Improvement meeting for 3 months . The committee will evaluate and make further recommendations as indicated.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/14/15

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to assess a resident that requested an as needed pain medication before administering the medication for 1 of 25 residents observed for medication pass (Resident #5). The findings included: Resident #5 was admitted to the facility on 11/25/14 with diagnoses of heart failure and cancer. The significant change Minimum Data Set (MDS) dated 04/21/15 revealed Resident #5 was severely cognitively impaired and had frequent pain. The care plan dated 04/21/15 revealed Resident #5 was at risk for potential medication toxicity related to administration of thyroid replacement and multiple medications. The goal was for Resident #5 to have no evidence of medication toxicity through the next review. Interventions included administer medications per order, monitor labs as ordered and obtain vital signs as indicated. Review of the physician orders dated 06/24/15 indicated Resident #5 had an order for hydrocodone/acetaminophen (pain medication) 5/325 milligrams (mg) take 2 tabs by mouth every 4 hours as needed for pain. Observation on 07/15/15 at 3:37 PM revealed Resident #5 told the Certified Medication Aide (CMA) #1 she needed a pain pill. CMA #1 went to the medication cart and obtained 2 hydrocodone/acetaminophen 5/325 mg tablets ordered for Resident #5 and administered the medication to Resident #5. CMA #1 did not assess Resident #5's pain or ask the nurse to	F 309	F309 SS=D Criteria #1 Certified Medication Aide was educated on scope of practice in the Skilled Nursing Facility and repeated the medication management program instructed by District Staff Development Coordinator or Director of Nursing. Criteria #2 An audit of all current residents who have received PRN pain medication since 7/15/2015 will be completed. Residents who were noted to have received PRN pain medication were interviewed to ensure they were having adequate pain management when PRN pain medications were administered. Data from interviews was noted and adjustments made to pain control if necessary. Criteria #3 100% of Certified Medication Aides and Nurses will be educated on scope of practice for CMA's when administering PRN pain medications and the nursing role in administration of PRN pain medications by Director of Nursing or Unit Managers. Unit Managers will observe medication administration to ensure	

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F 309	Continued From page 12 assess her pain before giving Resident #5 PRN pain medication. During an interview conducted on 07/15/15 at 5:15 PM with Nurse #3 she stated she was the nurse for the 200 hall on the 3:00 PM to 11:00 PM shift. Nurse #3 stated she had not assessed Resident #5 for pain during her shift and was not aware she had requested pain medication. An interview was conducted on 07/15/15 at 5:30 PM with CMA #1. She stated when a resident requests a PRN pain medication the nurse on the hall had to assess the resident's pain level and decide if the medication should be given. She stated she did not get the nurse to assess Resident #5's pain level before she administered the PRN pain medication. During an interview conducted on 07/17/15 at 12:03 PM with the Director of Nursing she stated the medication aide could not give PRN medications without having the nurse assess the resident first. She stated CMA #1 should have asked the nurse to assess Resident #5's pain before she administered her PRN pain medication.	F 309	Certified Medication Aide is having nurse assess each resident prior to administering PRN pain medication with 3 Certified Medication Aides on different shifts weekly for 4 weeks and then monthly for 3 months. Criteria #4 The results from the medication pass audits will be brought to QAPI monthly for 3 months and discussed. The committee will evaluate information and make further recommendations as indicated.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by:	F 318		8/14/15

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F 318	Continued From page 13 Based on observations, record reviews, and staff interviews, the facility failed to provide range of motion services for 1 of 3 residents reviewed for range of motion (Resident #32). Findings included: Resident #32 was admitted to the facility on 12/18/12. Diagnoses included muscle disuse atrophy. A quarterly Minimum Data Set (MDS) dated 06/09/15 indicated Resident #32 was cognitively intact and had range of motion limitations to both upper extremities and both lower extremities. During an interview with Resident #32 on 07/14/15 at 10:25 AM, both of the resident's hands and arms were observed with contractures and no splint in place, and the left hand and arm were more contracted than the right. Resident #32 stated he only had use of his right index finger and some range of motion in his right arm. He stated he had received occupational therapy in the past but was not currently receiving any kind of exercise at the time. Review of the Resident #32's care plan dated 07/15/15 revealed no problem area addressing the resident's limited range of motion or interventions to maintain or improve the current level of functioning. An interview was conducted with the Therapy Director on 07/16/15 at 2:59 PM. She stated occupational therapy had worked with Resident #32 to improve the range of motion in the resident's left hand through a variety of means. The Therapy Director further stated Resident #32 improved to his maximum potential and was discharged from occupational therapy to nursing in March 2015. She stated the expectation was for nursing to continue providing range of motion. An interview was conducted with Nurse Aide (NA) #1 on 07/16/15 at 4:05 PM. NA #1 stated	F 318	F318 SS=D Criteria 1- Resident #32 was evaluated by therapy on 07/23/2015 for decreased ROM. Criteria 2- Residents noted with limitations have the potential to be affected by this deficient practice. All resident assessed to have a decline per the MDS assessment will be referred to therapy for evaluation. Criteria 3- All Certified Nursing Assistants will be educated on ROM exercises and 4 modules of the restorative program including active ROM, passive ROM, ambulation and transfers by Rehab Manager. The Director of Nursing or Unit Managers will audit 4 residents weekly noted with a decline in MDS to ensure they were referred to therapy or are on a restorative program to prevent decline. Criteria 4- The Director of Nursing will bring results from audit to the monthly QAPI monthly for 3 months. The committee will review and make further recommendations as indicated.	

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F 318	Continued From page 14 Resident #32 was not receiving range of motion exercises. She further explained she was unaware of any recommendations from therapy regarding continued range of motion exercises. An interview was conducted with NA #4 on 07/16/15 at 4:15 PM. He stated the NAs typically did not provide range of motion exercises because daily care, such as dressing and showers, provided range of motion for the residents. An interview was conducted with the Director of Nursing (DON) on 07/17/15 at 11:57 AM. The DON explained Resident #32 should have been receiving some kind of regular exercises to prevent contractures and a decline in functioning. She also stated the NAs were encouraged to do range of motion exercises with residents but that was not happening.	F 318		
F 323 SS=G	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 record reviews and staff interviews the facility failed to provide supervision for a resident who fell from bed and fractured his right hip for 1 of 3 sampled residents for accidents. (Resident #192).	F 323	F323 SS=G Criteria #1- Resident # 192 was discharged on 02/09/2015. At the time of incident staff	8/14/15

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F 323	Continued From page 15 The findings included: Resident #192 was admitted to the facility on 02/04/15 with diagnoses which included anemia, acute kidney failure, lung disease, high blood pressure and malnutrition. Resident #192 was discharged from the facility to the hospital on 02/09/15 and did not return to the facility. A review of a discharge Minimum Data Set (MDS) dated 02/09/15 indicated Resident #192 had no short term memory impairment and he was independent in cognitive skills for daily decision making. The MDS also indicated Resident #192 required extensive assistance with transfers and required supervision while walking in his room and he had a nephrostomy tube (a tube placed through the abdomen for drainage of urine) and he was occasionally incontinent of bowel. A review of an interim plan of care dated 02/04/15 indicated potential and actual falls due to a history of falls, decreased safety awareness and weakness. The goals indicated Resident #192 would be free of fall related injury through next review and interventions included in part for pressure pad alarm, call light within reach and a bed alarm. A review of a facility document titled Fall Risk Evaluation dated 02/04/15 revealed Resident #192 had a total risk score of 14 (a score of 10 or greater represented high risk for falls). A review of a facility document titled Fall Risk Evaluation dated 02/09/15 revealed a total risk score of 18 and indicated predisposing disease of weakness and a history of falls. A review of a facility document titled Situation,	F 323	education was completed on Standards of Certified Nursing Assistant Practice. An Ad Hoc QAPI was held to review the opportunity for improvement and the action taken. Corrective actions were implemented. Criteria #2- Residents at risk for falls have the potential to be affected by this alleged deficient practice. Criteria #3- The Director of Nursing or Unit Manager will conduct re-education for nursing staff on Standards Of Certified Nursing Assistant Practice, to include making routine rounds to ensure residents needs are met. Director of Nursing or Unit Manager will conduct weekly random rounds on residents at risk for falls, of Resident Care Specialist to ensure they are following Standards of practice for Certified Nursing Assistants, audits to include all shifts on10 residents weekly for 4 weeks and then on 10 residents monthly for 3 months. Criteria #4- Concerns will be addressed immediately by DON or Unit Manager. The results of the audits will be reported monthly for 3 months during The QAPI meeting and the plan will be amended as appropriate. The committee will evaluate and make further recommendations as needed.	

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Background, Assessment and Request (SBAR) communication form and progress note dated 02/09/15 indicated Resident #192 had a fall on 02/09/15. The section labeled Background indicated Resident #192 had a urinary tract infection, kidney failure and anemia. A section labeled Request included nurse's notes and revealed Resident #192 was lying on the floor and when asked why he was in the floor he stated he was going to the bathroom and fell. The notes indicated in part Resident #192 was able to move all extremities without any difficulty, had no complaints of pain and he was lifted back to bed and his back and buttocks were assessed after he was in bed and no redness or broken areas of skin were noted.

A review of an incident and accident report dated 02/09/15 indicated the date of incident was 02/09/15 at 4:30 AM and the location was in the resident's room. The report indicated the resident's description of the incident when he was found lying beside his bed revealed he was going to the bathroom and fell. A section labeled equipment involved was checked as no and a section labeled resident outcome was checked as no apparent injury. A section labeled description of incident and accident indicated a primary assessment was completed when he was in bed and he was turned on his side for the nurse to do the assessment.

A review of a physician's progress notes dated 02/09/15 but did not have a time documented revealed in part Resident #192 had a fall on 02/09/15 in the early morning. The notes indicated Resident #192 stated he was attempting to get to the bathroom and fell and thought he landed on his back but denied hitting

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his head. The notes further indicated Resident #192 was complaining of right hip and groin pain and he was alert and oriented to time, place and person and was lying in bed guarding his right hip. The notes revealed Resident #192 was frail and had general wasting of his body and his right lower extremity was shortened and was externally rotated (turned outward) and he complained of pain with palpation of his right femur (thigh bone). The notes further revealed x-rays were ordered and to continue neurological checks and fall precautions.

A review of an x-ray report dated 02/09/15 indicated the right hip showed an acute, slightly angulated intertrochanteric (the upper part of the thigh bone) fracture and osteopenia (reduced bone mass of lesser severity than osteoporosis) was present and there were degenerative changes.

A review of a physician's order dated 02/09/15 indicated to transport Resident #192 to the emergency room for acute right intertrochanteric fracture.

A review of a Resident Transfer Form dated 02/09/15 with no time documented indicated to transfer Resident #192 to the hospital and the reason for transfer was right femur fracture. No time of transfer was documented.

A review of a Nursing Daily Skilled Summary dated 02/09/15 at 2:00 PM revealed in part Resident #192's right hip was found to be positive for fracture by x-ray at 11:45 AM and he was sent out to the hospital for evaluation.

During an interview on 07/15/15 at 2:53 PM with

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Resident #192's roommate who was cognitively intact for daily decision making he explained he remembered the night Resident #192 rolled out of bed onto the floor. He stated prior to the fall a Nurse Aide (NA) was in the room around 11:00 PM on 02/08/15 and provided care to Resident #192. He further stated no staff came back into the room after that until Resident #192 rolled out of bed and hit the over bed table and it bumped into his bed and he looked and saw Resident #192 on the floor. He explained he pushed the call light but nobody came to the room so he sent a text on his phone to a family member to call the nurse's station to tell them to check on Resident #192. He confirmed he sent the text message at 4:28 AM and a nurse came in the room at 4:36 AM. He explained the nurse called for assistance and another nurse and 2 Nurse Aides (NAs) came into the room and picked Resident #192 up off the floor and put him in the bed. He stated he asked Resident #192 what had happened and he said he needed to go to the bathroom and fell.

During a phone interview on 07/15/15 at 3:50 PM with a family member of Resident #192 she stated Resident #192 had hip surgery after he went to the hospital and was discharged to another facility but had recently expired because he never recovered and could not walk. She further stated the roommate had reported to her that NAs had not checked on Resident #192 during the night and he had to text his family to call the nurses station because they did not answer the call light.

During an interview on 07/17/15 at 10:23 AM with Certified Medication Aide #2 she explained she arrived at the facility at 3:00 AM on 02/09/15. She explained at night there was 1 Nurse Aide on

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the hall where Resident #192 lived to provide care to residents. She stated NAs were supposed to do rounds and check on residents every 2 hours or more often as needed. She further stated she did not go into Resident #192's room on 02/09/15.

During an interview on 07/17/15 at 10:43 AM with Nurse #4 who identified herself as a Unit Manager of the unit where Resident #129 lived explained when she arrived at the facility in the morning on 02/09/15 after Resident #192's fall Nurse #5 who was assigned to Resident #192's care on the night shift stated he was found on the floor in his room around 4:30 AM. She stated Nurse #5 also reported she had assessed Resident #192 and she didn't think he was injured.

During an interview 07/17/15 at 11:16 AM with a Nurse Practitioner she explained she saw Resident #192 on 02/09/15 during the morning after his fall. She stated she got to the facility around 8:00 AM and the nurses told her he had fallen and she went to his room. She stated Resident #192 was alert with clear speech and he told her he was trying to go to the bathroom. She explained when she examined him he was very guarded with his right leg and it was shortened and externally rotated. She stated Resident #192 was complaining of right hip and groin pain and she thought he had fractured his hip or leg so she ordered x-rays to be done immediately in the facility and the results showed a right hip fracture. She further stated she then wrote orders to send him to the hospital

During an interview on 07/17/15 at 12:21 PM with Nurse #2 he explained he was the day shift nurse

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on 02/09/15 after Resident #192 had a fall and received report from Nurse #5. He stated Nurse #5 reported to him that Resident #192 had fallen and was found on the floor in his room around 4:30 AM. He explained she said she checked for range of motion in Resident #192's legs, his pain level and said he appeared to be alright. He stated he saw Resident #192 later that morning and he complained of pain and he gave him pain medication. He further stated he was not sure if Resident #192 was a fall risk and did not recall fall prevention interventions.

During an interview on 07/17/15 at 2:22 PM with Nurse #5 who was assigned to care for Resident #192 during the night shift on 02/09/15, she stated she was going down the hall to take a resident a snack around 4:30 AM and then she looked in on Resident #192 and he was lying in the floor next to his bed. She stated she had not been in Resident #192's room since the beginning of her shift at 11:00 PM. She further stated she assessed Resident #192 while he was in the floor and she didn't see any obvious injury so she called for NAs to help her put him back in bed. She explained NAs were supposed to do rounds and check on resident's every 2 hours or more often as needed but no one had checked on Resident #192 after 11:00 PM that she was aware of.

During an interview on 07/17/15 at 3:28 PM with the Area Staff Development Manager she explained she was the former Director of Nursing (DON) in the facility when Resident #192 fell on 02/09/15. She stated when she got to the facility staff told her Resident #192 had fallen. She stated she started an investigation but did not interview Resident #192 because he was sent to

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F 323	Continued From page 21 the hospital. She stated she got a statement from the NA who was assigned to Resident #192 during the night shift and was told she assisted Resident #192 with care at 11:15 PM and did not go back in his room after that. She confirmed the NA no longer worked at the facility and attempts to contact her by phone were unsuccessful. She stated it was her expectation that staff should make rounds and check on residents every 2 hours or more often as needed.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the medication pass, record review and staff interviews the facility failed to ensure a medication error rate less than 5% as evidenced by 2 errors (pain patch and Parkinson's disease medication) out of 25 opportunities which resulted in a medication error rate of 8% for 2 of 7 residents observed during the medication pass (Resident #5 and #11). The findings included: 1. Resident #5 was admitted to the facility on 11/25/14 with diagnoses of heart failure, cancer and chronic obstructive pulmonary disease. The significant change Minimum Data Set (MDS) dated 04/21/15 revealed Resident #5 was severely cognitively impaired and had frequent pain. Review of the July 2015 physician orders indicated Resident #5 was to receive a fentanyl	F 332	F332 SS=D Criteria #1 Medication variance procedure was completed for non-compliant time of medications administered to resident #5 and resident #11. Criteria #2 All residents have the potential to be affected. Criteria #3 The Area Staff Development Coordinator/Director of Nursing and or	8/14/15

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F 332	Continued From page 22 patch (a medication patch used to treat moderate to severe chronic pain) 75 micrograms/hour to be changed every 72 hours at 5:00 PM. Observation on 07/15/15 at 3:36 PM revealed the Certified Medication Aide (CMA) removed Resident #5's fentanyl patch. The CMA had the registered nurse observe her discard the patch into the trash container. The CMA then dated and timed the new fentanyl patch and applied it to Resident #5's upper back at 3:42 PM. Interview with the CMA on 07/15/15 at 3:55 PM revealed the facility policy for medication administration was 1 hour before or 1 hour after the medication was ordered to be given. She stated she applied the fentanyl patch too early and did not realize it was a 5:00 PM medication. An interview was conducted on 07/17/15 at 12:03 PM with the Director of Nursing (DON). She stated the facility policy for medication administration was 1 hour before or after the medication was ordered to be given. She stated it was her expectation that all medications were given in the correct time frame and if they were given outside the hour window the physician should be notified and a medication error report should be filed. 2. Resident #11 was admitted to the facility on 01/23/12 with diagnoses of Parkinson's disease and hypertension. The quarterly Minimum Data Set (MDS) dated 04/17/15 revealed Resident #11 was moderately cognitively impaired. Review of the July 2015 physician orders revealed Resident #11 received carbidopa/levo ER (medication used to treat Parkinson's disease) 25-100 milligrams 4 times a day due at 9:00 AM, 1:00 pm, 5:00 PM and 9:00 pm. Observation on 07/17/15 at 2:20 PM revealed Nurse #2 administered Resident #11's carbidopa/levo 25-100 milligrams at 2:20 PM.	F 332	Unit Managers will re-educate all Licensed Nurses on Medication Administration Time Compliance. The Area Staff Development Coordinator, Director of Nursing and or Unit Manager will randomly audit 5 Licensed Nurse and or Certified Medication Aide weekly for 4 weeks and then monthly for 3 months to ensure compliance with Medication Administration time compliance. Criteria #4 The results of the audits and monitoring will be reported in the QAPI meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated.	

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	345312	A. BUILDING _____ B. WING _____	07/17/2015

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F 332	Continued From page 23 During an interview conducted on 07/17/15 at 3:26 PM with Nurse #2 he stated the facility policy for medication administration was medications could be given 1 hour before or after they were ordered. He stated if medications were given outside of that time frame the physician should be notified and a medication error report should be completed. Nurse #2 stated he was behind in his medication pass and did not notify the physician the medication was given late. An interview was conducted on 07/17/15 at 12:03 PM with the Director of Nursing (DON). She stated the facility policy for medication administration was 1 hour before or after the medication was ordered to be given. She stated it was her expectation that all medications were given in the correct time frame and if they were given outside of the hour window the physician should be notified and a medication error report should be filed.	F 332		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		8/14/15

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F 514	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to document time of a resident fall and time of nurses notes on a change of condition form, time of nurse practitioner assessment, time of transfer to a hospital and failed to document severity and location of pain and effectiveness of pain medication for a resident who had a fractured hip after he fell from bed for 1 of 3 residents sampled for accidents. (Resident #192). The findings included: Resident #192 was admitted to the facility on 02/04/15 with diagnoses which included anemia, acute kidney failure, lung disease, high blood pressure, glaucoma and malnutrition. Resident #192 was discharged from the facility to the hospital on 02/09/15 and did not return to the facility. A review of a discharge Minimum Data Set (MDS) dated 02/09/15 indicated Resident #192 had no short term memory impairment and he was independent in cognitive skills for daily decision making. The MDS also indicated Resident #192 required extensive assistance with transfers and required supervision while walking in his room. A review of a facility document titled Interdisciplinary Post Fall Review dated 02/09/15 indicated time of Resident #129's fall was 4:30 AM. A review of a facility document titled Situation, Background, Assessment and Request (SBAR) communication form and progress note dated 02/09/15 indicated Resident #192 had a fall on	F 514	F514 SS=D Criteria #1 Resident #192 discharged on 2/9/2015. Criteria #2 Facility residents that have fallen have the potential to be affected by this alleged deficient practice. Director of Nursing will audit records of residents who have fallen in the past 30 days for complete and accurate documentation to include date and time of transfer, assessment, and signs and symptoms of pain. Criteria #3 Director of Nursing and/or Unit Managers will provide education to nurses, nurse practitioners, and attending physicians on documentation requirements to include documenting date and time on change of condition of residents who have fallen, Nurse Practitioner and Doctor assessments, transfer forms and documenting and assessing pain. The Director of Nursing or Unit Managers will audit 10 residents charts who have fallen or have been transferred to hospital, to ensure complete and accurate documentation weekly for 4 weeks, then monthly for 3 months. Criteria #4	

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F 514	Continued From page 25 02/09/15 but there was no documentation for time of the fall and a section of handwritten nurses notes did not have a time documented. A review of a Medication Administration Record indicated Resident #192 received Tramadol 50 milligrams (mg) by mouth for hip pain on 02/09/15 at 6:30 AM but there was no documentation of the level of pain on a scale of 0 (no pain) to 10 (worst pain) and there was no documentation of the effectiveness of the pain medication. A review of a Medication Administration Record dated 02/09/15 indicated Resident #129 was given Dilaudid 4 mg by mouth for pain at 10:05 AM but there was no documentation of the location of pain and there was no documentation of the level of pain on a pain scale of 0-10. A review of physician's progress notes dated 02/09/15 did not include documentation of the time the Nurse Practitioner saw Resident #192. A review of a MAR dated 02/09/15 indicated Resident #129 received Dilaudid 4 mg by mouth on at 12:45 PM for complaint of pain but there was no documentation of the level of pain on a scale of 0-10, there was no documentation of the location of pain and there was no documentation of the medication's effectiveness. A review of a Nursing Daily Skilled Summary dated 02/09/15 at 2:00 PM indicated neuro checks had been continued for post fall and right hip was found to be positive for fracture at 11:45 AM and Resident #192 had been sent to the hospital for hip evaluation. A review of a facility document titled Resident	F 514	The results of the audits will be reported in the QAPI meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated.	

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Transfer Form dated 02/09/15 did not include time of transfer to the hospital.

During an interview on 07/17/15 at 10:43 AM with Nurse #4 who identified herself as a Unit Manager of the unit where Resident #129 lived stated after she reviewed the documentation in Resident #129's medical record there should have been documentation of the time of Resident 129's fall and time nurses notes were documented on the on the SBAR form and the time of transfer to the hospital on the resident transfer form. She explained nursing staff had documented neurological checks every 30 minutes on a Neurological Record as their assessment of Resident #129 but it did not include information about Resident's severity of pain. Nurse #4 confirmed the severity of Resident #129's pain was not documented but should have included the severity of his pain according to the pain scale from 0-10. She further stated Resident #129 was alert and oriented and would have been able to state what his pain level was. She also stated she expected to see documentation of the location of pain and the effectiveness of pain medication.

During an interview on 07/17/15 at 11:16 AM the Nurse Practitioner stated she forgot to document the time she saw Resident #129 on 02/09/15. She stated she was working on trying to remember to put the time with the date when she documented her notes.

During an interview on 07/17/15 at 12:21 PM with Nurse #2 he explained he was the day shift nurse after Resident #192 had a fall on 02/09/15 and gave Resident #129 pain medication. He verified he gave Resident #129 pain medication at 10:05

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AM because he complained of hip pain and gave pain medication again at 12:45 PM just before Resident #129 left the facility to go to the hospital because of continued hip pain. He explained Resident #129 was not in severe pain but described his pain as "moderate." He further explained he was supposed to document severity of pain with a pain scale from 0-10 but he did not document Resident #129's severity of pain because there was no place to write it on the MAR and he had forgotten to document location of pain or pain medication effectiveness.

During an interview on 07/17/15 at 2:22 PM with Nurse #5 who was assigned to care for Resident #192 during the night shift she confirmed she filled out the SBAR form and the notes on the form were her nurse ' s notes. She stated she assessed Resident #129 while he was on the floor and again after they put him to bed. She further stated that Resident #129 did not complain of pain when she found him in the floor but later he complained of pain and she gave him pain medication. She stated she did not recall the severity of his pain but stated he was not in severe pain and she had forgotten to document the level of his pain according to the pain scale and effectiveness of the pain medication. She further stated she did not know why she did not put the time of Resident #192's fall or the time she documented her nurse's notes on the SBAR form but she must have forgotten it.

During an interview on 07/17/15 at 3:28 PM with the Area Staff Development Manager explained she was former Director of Nursing (DON) in the facility when Resident #192 fell on 02/09/15. She stated it was her expectation that the time of Resident #129's fall and time nurses notes should

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F 514	Continued From page 28 have been documented on the SBAR form and the time of transfer to the hospital should have been documented on the transfer form. She stated she also expected to see documentation of the severity of the pain, location of pain and if pain medication was effective on the MAR or in the nurses notes.	F 514		