STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN HEALTHCARE & REHAB CENTER	208 MERCER ROAD ELIZABETHTOWN, NC 28337

(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 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; 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.	F 272		11/13/15

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

Electronically Signed | 11/18/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately assess one of seven residents for the use of side rails (Resident #95). Findings included: Record review indicated Resident #95 was admitted on 6/26/2015. The resident's diagnoses included Dementia without behavioral disturbances, Alzheimer ' s, Restlessness and Agitation. The Minimum Data Set (MDS) dated 7/2/2015 indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance of 2 persons for positioning. An MDS side rail assessment dated 9/24/2015 indicated the resident was non ambulatory, comatose, semi-comatose and fluctuating level of consciousness. The assessment also indicated the resident had difficulty with balance and was on medications that required increased safety precautions. At the end of the assessment, the decision for use of bed rails was not completed, and no decision was documented for the use of side rails. An MDS progress note dated 9/24/2015 indicated the resident was totally dependent of one person assist for positioning. The resident was observed on the initial tour on 10/26/2015 around 6:30 PM in her room. She was lying on her back on her bed. Both full metal side rails were raised. In an interview with the MDS nurse on 10/30/2015, the nurse reported when she did the quarterly side rail assessment and did not document a decision or conclusion on 9/24/2015, it was because she did not agree with any of the	F 272	F272 Standard Disclaimer: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). For the resident found to have been affected by the alleged deficient practice, the following corrective action was taken: Resident #95: The resident was re-assessed regarding the use of side rails. A new "Side Rail Screen" form was completed to accurately assess the resident's needs and functional capacity regarding the use of side rails. Resident #95 was care planned accordingly. (See Attachment #1) For the residents having the potential to be affected by the same alleged deficient practice, the following corrective action was taken: A new "Side Rail Screen" was completed on each resident to assess the need for side rail usage according to the resident's needs and functional capacity. (See Attachment #2; 69 pages) A new "Side Rail" policy has been	

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F 272	Continued From page 2 3 choices for use of side rails. She further stated "I guess I could have put a comment on the assessment. She has them for positioning. I should not have left it blank." The facility Administrator was interviewed on 10/30/2015 at 10:54 AM and stated the expectation was residents should be accurately assessed by staff.	F 272	developed for the facility. (See Attachment #3) Nurses received in-service education on the new Side Rail policy and how to assess the integrity of the side rails. (See Attachment #4) In addition, the Administrator and MDS Coordinator have reviewed the Side Rail Screen form and the MDS Coordinator is aware that the Side Rail Screen form has to be accurate and filled out in its entirety. Furthermore, the MDS Coordinator shall ensure that those residents requiring the use of side rails due to a physical functioning and/or structural problem with a qualifying diagnosis have physician's order and are care planned accordingly and that the care plans reflect the current interventions. The Administrator, Director of Nursing and Quality Assurance Nurse will conduct Side Rail Screen audits on residents using side rails. The audit will be conducted on admissions, readmissions, quarterly, significant changes or incidents/injuries assessments occurring while resident using the device. Additionally, the audits will determine if the screens are accurate determining the need for side rails. The Administrator, DON and QA Nurse will conduct audits monthly for six months. Thereafter, audits will be conducted quarterly, according to the care plan calendar to maintain compliance.	

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F 272	Continued From page 3	F 272	All data will be summarized and presented by the DON or QA Nurse at the monthly QAPI meeting. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, QA Nurse, MDS Coordinator, Wound Nurse, Medical Director, and Environmental Services. Other member may be assigned as the need should arise. The QA nurse will check Side Rail Assessments for completion and accuracy on admission, readmission, significant change, quarterly and monthly chart audits. The Administrator will monitor for compliance. Any discrepancies noted during the chart audits shall be presented to the QAPI Committee monthly for three months, then quarterly thereafter to ensure compliance.	
F 323 SS=E	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.	F 323		11/16/15

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F 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews, the facility failed to provide safe side rails for seven of seven residents with side rails (Residents #13, 20, 32, 95, 31, 94 and 58). Findings included: 1. Record review indicated Resident #13 was admitted to the facility on 12/12/2014. The resident's Minimum Data Sets (MDS) dated 9/8/2015 indicated the resident had no cognitive impairment. The MDS indicated the resident required extensive assistance of one person for positioning and turning. A side rail screen dated 9/8/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence. An observation on 10/27/2015 at 11:16 AM was done in the resident ' s room. The resident was lying on the bed, and full side rails were up on both sides of the bed. The rails were loose, and a space approximately 5 inches was measured between the rails and mattress. 2. Record review indicated Resident #20 was admitted to the facility on 4/19/2013. The resident's current cumulative diagnoses included Dementia and Anxiety. The resident's Minimum Data Sets (MDS) dated 10/6/2015 indicated the resident had severe cognitive impairment. The MDS indicated the	F 323	F323 Standard Disclaimer: This Plan of Correction is prepared as a necessary requirement for the continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). For those residents found to have been affected by the alleged deficient practice, the following corrective action was taken immediately: For Residents'(#13,20,32,95,31,94 and 58) - the alleged unsafe side rails were immediately removed. The residents were re-assessed for the use of side rails, using the Side Rail Screen form. Resident's were care planned accordingly. For the resident's having the potential to be affected by the same alleged deficient practice, the following corrective action was taken immediately: Side rails found to be unsafe were removed from beds. A new "Side Rail" policy has been developed for the facility.	

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F 323	Continued From page 5 resident required extensive assistance of one person for positioning and turning. A side rail screen dated 10/6/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance, was on medications which would require increased safety measures, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence. An observation on 10/27/2015 at 4:20 PM was conducted of the resident ' s side rails. The side rail on the right side of bed was raised and locked into position. The rail was very loose when moved from side to side. There was space between the rail and the mattress which measured 5 ½ inches. 3. Record review indicated Resident #32 was admitted to the facility on 9/14/2009. The resident's cumulative diagnoses included Vascular Dementia with behavioral disturbances. The resident's Minimum Data Sets (MDS) dated 7/6/2015 and 10/5/2015 indicated the resident had severe cognitive impairment and required extensive assistance with transfers and positioning. A side rail screen dated 7/6/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance was on medications which required increased safety precautions, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence. The resident was observed lying on her bed on	F 323	Nurses received in-service education on the new Side Rail policy and how to assess the integrity of the side rails. All residents were re-assessed by using the Side Rail Screen form. The form assesses the need for side rail usage according to the residents' needs and functional capacity. The Side Rail policy was followed for the residents needing to use side rails. The Maintenance Director and/or designee will conduct audits on an ongoing basis to observe side rail integrity/safety. The audits will be conducted daily for three months, after the three months, the residents will be re-evaluated for the continued use of the side rails. The Maintenance Director and/or his designee will continue daily audits of the side rails for integrity/safety to ensure compliance. Any unsafe side rails that have been removed or other areas of concern with the side rails noted during audits will be presented by the Maintenance Director at monthly QAPI meeting. Any trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, QA Nurse, MDS Nurse, Medical Director, Wound Nurse and Environmental Services. Other members may be assigned as the need	

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F 323	Continued From page 6 her back on 10/27/2015. The head of the bed was elevated 30 degrees. The resident was awake on approach. The resident mumbled various words when spoken to. Full side rails were observed up on both sides of the bed. The rails were very loose when checked, and there was a gap between the mattress and the rails on both sides approximately 5 inches. 4. Record review indicated Resident #95 was admitted on 6/26/2015. Diagnoses included Dementia without behavioral disturbances, Alzheimer ' s and Restlessness and Agitation. The MDS dated 7/2/2015 indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance of 2 persons for positioning. A side rail assessment dated 9/24/2015 indicated the resident was non ambulatory, comatose, semi-comatose and fluctuating level of consciousness. The assessment also indicated the resident had difficulty with balance and was on medications that required increased safety precautions. The assessment indicated the resident was not currently using side rails. At the end of the assessment, the decision for use of bed rails was not completed. The resident was observed on the initial tour on 10/26/2015 around 6:30 PM in her room. She was lying on her back on her bed. Both full metal side rails were raised. The rails had a parallel bar between the top and bottom rail running the length of the rail. Both rails were loose when checked and moved very easily away from the bed and mattress. On the left side of the bed, the space noted between the mattress and the side rail was approximately 5-6 inches before moving the side rail. 5. Record review indicated Resident #31 was admitted to the facility on 10/20/2006.	F 323	should arise.	

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F 323	Continued From page 7	F 323		

The resident's Minimum Data Sets (MDS) dated 3/5/2015 indicated the resident had severe cognitive impairment. The MDS indicated the resident was totally dependent of one person for positioning and turning.
A side rail screen dated 9/2/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence.
An observation was conducted in the resident ' s room on 10/28/2015 at 9:57 AM. Both full side rails were observed in the up position with resident lying on the bed. The rails on both sides were loose when checked, pulled away from bed easily leaving a gap of approximately 5 inches between the mattress and the rails.
6. Record review indicated Resident #94 was admitted to the facility on 12/30/2014.
The resident's Minimum Data Sets (MDS) dated 1/5/2015 indicated the resident had no cognitive impairment. The MDS indicated the resident required total dependence of one person for positioning and turning.
A side rail screen dated 9/24/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence.
The resident was observed lying on her bed on her back on 10/27/2015. The head of the bed

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F 323	Continued From page 8	F 323		

was elevated 30 degrees. The resident was awake and alert on approach. The rails were very loose when checked, and there was about a 4 to 5 inch gap between the mattress and the rails on both sides.

7. Record review indicated Resident #58 was admitted to the facility in 2014. The resident's cumulative diagnoses included Unspecified abnormalities of gait and mobility.

The resident's Minimum Data Sets (MDS) dated 10/14/2015 indicated the resident had no cognitive impairment. The MDS indicated the resident required extensive assistance of one person for positioning and turning.

A side rail screen dated 10/12/2015 indicated the resident was non-ambulatory, exhibited poor bed mobility or difficulty moving in bed, had poor balance, no reason to believe resident could climb over side rails and expressed a desire to have side rails raised while in bed. The decision following the assessment indicated side rails were indicated and serve as an enabler to promote independence.

An observation was conducted in the resident ' s room on 10/28/2015 at 10:26 AM. The resident was lying on the bed. Two full side rails were observed in the up position. Both rails were very loose when touched and pulled away easily from the side of the bed.

The Maintenance Director was interviewed on 10/30/2015 at 9:37 AM. He stated the beds and rails were being used in the facility when he was hired 12 years ago. He stated they probably weren ' t made anymore, and he had no manufacturer information for the bed or rails.

The facility Administrator was interviewed on 10/30/2015 at 10:54 AM. The Administrator stated most of the beds/rails were older and not manufactured anymore. She also stated the

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F 323	Continued From page 9 facility was phasing the old beds and rails out and replacing them a few at a time with new rails. The Administrator further stated no injuries had occurred related to bed rails.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and date open nourishment items in the refrigerator and freezer in 1 of 2 nourishment rooms and the facility failed to monitor temperatures in the refrigerators and freezers in 2 of 2 nourishment rooms. Findings Included: Observations of the 100 & 200 Hall nourishment room refrigerator on 10/29/15 at 10:00 A.M. revealed no thermometer observed in the refrigerator and freezer. In the freezer, there were 3 opened bottles of water, frozen solid, not labeled and dated. In the refrigerator, there were 2 styrofoam cups which contained applesauce, a fast food bag which contained food and 2 pitchers which contained water not labeled and dated. No food spoilage was noted. Observations of the 300 & 400 Hall nourishment	F 371	F 371 Standard Disclaimer: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were found to have been affected by this alleged deficient practice(s). For any residents having the potential to be affected by the same alleged deficient practice(s), the following corrective	11/19/15

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F 371	Continued From page 10 room refrigerator on 10/29/15 at 10:30 A.M. revealed no thermometer in the refrigerator or freezer. On 10/29/15 at 10:00 A.M., the Dietary Manager was interviewed and reported the dietary department staff were responsible for stocking nourishment items for the residents in the nourishment room refrigerators. She reported housekeeping staff were responsible for checking the dates on all items in the nourishment room refrigerators and discarding any items after they had been there 3 days. The Dietary Manager stated daily refrigerator and freezer temperatures were not taken. On 10/29/15 at 10:15 A.M., the Housekeeping Manager was interviewed and reported every Tuesday, the housekeeping staff cleaned the refrigerators and removed outdated nourishment items and she stated items were to be labeled and dated. She stated items brought from family members for residents were to be labeled and dated by nursing. The Housekeeping Manager stated the Maintenance Manager was responsible for recording the temperatures of the nourishment room refrigerators. On 10/29/15 at 11:05 A.M., the Maintenance Manager was interviewed and reported he was not responsible for monitoring the nourishment room refrigerator and freezer temperatures or maintaining a log. On 10/30/15 at 2:40 P.M., in an interview with the Administrator, the Administrator stated the expectation of the nourishment room refrigerators and freezers were the refrigerator temperatures be maintained at 35-40 degrees and the freezer temperatures below 32 degrees. She stated the temperatures were to be checked daily and recorded on a log kept on the front of the refrigerator. She stated any nourishment items	F 371	actions were put into place immediately: Thermometers were placed in the 100/200 hall nourishment room refrigerator and freezer and the 400 hall refrigerator and freezer. Both thermometers are reading the correct temperatures of 35-40 degrees in the refrigerator section and the freezer sections were well below 32 degrees. Any unlabeled food items were discarded immediately. Items that were labeled and had been in the refrigerator/freezer for 3 days were discarded as well. A daily temperature log has been established for each refrigerator / freezer and is placed on the front of the appliance. The Housekeeping Supervisor will maintain a file of the monthly logs. (See Attachment #5) The Housekeeping Supervisor and housekeeping staff have been educated and instructed to check the temperatures in both the refrigerator section and freezer section of the appliances and document temperatures daily on the temperature log attached to the front of the appliances. In conjunction with going over the temperature logs, the housekeeping staff have been reminded that all unlabeled items in the appliances have to be discarded daily and labeled items discarded on the 3rd day from the date labeled. (See Attachment #6 & #7) Sign placed on appliances to remind	

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F 371	Continued From page 11 kept in the nourishment room refrigerator for 3 days would be discarded.	F 371	staff/residents/family members to label and date all food items placed in the refrigerator and/or freezer. The Housekeeping Supervisor will audit the nourishment kitchen refrigerators and temperature logs for temperature range and labeled/unlabeled food items on a daily basis for three months to determine compliance. Thereafter, if the housekeeping staff have been compliant, the Housekeeping Supervisor may audit weekly for three months to ensure compliance. Any discrepancies noted during audits will be presented by the Housekeeping Supervisor to the QAPI Committee during the monthly meetings. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, QA Nurse, MDS Nurse, Wound Care Nurse, Medical Director and Environmental Services. Other members may be assigned as the need should arise.	