STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment on radiation and chemotherapy treatment, range of motion exercises and splinting and the use of psychotropic medication for 2 (Resident #39 & #	F 278	F278 For the resident found to have been affected by the alleged deficient practice, (#39 & #99), a MDS correction was submitted on 12-2-15 by the MDS coordinator.	12/17/15

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

Electronically Signed | 12/14/2015

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F 278	Continued From page 1 99)of 20 sampled residents reviewed. Findings include: 1a. Resident #39 was originally admitted to the facility on 6/29/15. On 8/11/15, there was a doctor's order for " soft bean bag to left lower extremity (knee) up to eight hours per day, check every 2 hours for redness. " The significant change in status Minimum Data Set (MDS) assessment dated 10/30/15 indicated that Resident #39 did not receive passive range of motion (PROM) and splinting during the assessment period. The resident's care plan with the revised date of 11/2/15 included approaches for restorative to perform PROM and splinting six times per week to bilateral knees. The restorative nursing program flow records for October, 2015 were reviewed. The records indicated that Resident #39 was provided PROM and splinting from October 27-31, 2015. On 12/2/15 at 10:02 AM, NA #1 (restorative aide) was interviewed. She indicated that Resident #39 was on their work load and PROM and splinting were provided to the resident daily. On 12/2/15 at 12:25 PM, MDS Nurse was interviewed. She acknowledged that the coding for the PROM and splinting for Resident #39 were inaccurate and she would complete a correction MDS assessment. 1b. Resident #39 was originally admitted to the facility on 6/29/15. The Medication Administration Records for October, 2015 were reviewed. The records indicated that Resident #39 had received oral chemo therapy while at the facility and the treatment was completed on 10/22/15. The	F 278	For those residents having the potential to be affected by the same alleged deficient practice, the MDS Nurse will audit 100% of resident assessments to determine that any restorative, radiation and chemotherapy and psychotropic medications have been properly assessed. Audit resulted that six inaccuracies were found and MDS corrections were submitted by December 14, 2015. To ensure that this alleged deficient practice does not reoccur, the following measures will be put into place. The MDS coordinator was in serviced on 12-3-15 by MDS Consultant. The in service included the facility procedures on coding MDS assessments, RAI manual review, and coding from all documentation in residents chart. The Patients at Risk committee meets weekly on Wednesday's and consists of MDS coordinator, Dietary Manger, Administrator, DON, Clinical Supervisors and Wound Nurse. The Patients at Risk committee will review five MDS assessments weekly for four weeks and five MDS assessments a month for four months alternating different residents in each MDS assessment review period, starting on 12-11-15. The Patient at Risk committee will be reviewing accuracy of the MDS assessments by auditing the Medication Administration Record, Treatment Administration Record, Restorative Flow Sheets, ADL flow sheets, Nursing Notes, MD orders & Visits, Therapy, Wound nurse assessments, and Vohra assessments.	

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F 278	Continued From page 2 records also indicated that the resident had received radiation therapy and the treatment was completed on 10/20/15. The significant change in status Minimum Data Set (MDS) assessment dated 10/30/15 indicated that Resident #39 did not receive radiation and chemo therapy while at the facility during the assessment period. On 12/2/15 at 12:25 PM, the MDS Nurse was interviewed. She acknowledged that the coding for the radiation and chemo therapy were not accurate and she would complete a correction MDS assessment. 2. Resident #99 was admitted to the facility on 3/18/15 and readmitted on 4/30/15 with multiple diagnoses that included dementia. The quarterly MDS dated 9/19/15 indicated Resident #99 had significant cognitive impairment. The Medications Section of the 9/19/15 MDS indicated Resident #99 received antidepressant medications on seven days and antianxiety medications on zero days during the seven day look back period. A review of the Medication Administration Record (MAR) for the look back period revealed Resident #99 received antidepressant medications on zero days and antianxiety medications on seven days. An interview was conducted on 12/02/15 at 3:40 PM with the MDS nurse. She stated that she was responsible for completing the MDS. She reviewed the 09/19/15 MDS for Resident #99. She revealed that the Medications Section was coded incorrectly and should have indicated zero days for antidepressants and seven days for	F 278	The DON will record findings of inaccuracy of the MDS assessments and the MDS coordinator will correct the inaccurate MDS assessment before transmission. This information will be recorded on a MDS assessment tracking sheet and brought to our monthly QA meeting by the DON. In order to monitor our performance and to make sure that these solutions are sustained, any resident identified going forward will be discussed at the weekly Patient at Risk committee meeting which consists of, MDS coordinator, Dietary Manger, Administrator, DON, Clinical Supervisors and Wound Nurse. This committee will identify any inaccuracy MDS assessments of the residents that are audited in that month. The DON will bring resident's name and the inaccuracy that occurred to our monthly QA meeting. The DON will review/audit our compliance weekly for four weeks, then monthly for four months.	

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F 278	Continued From page 3 antianxiety medications.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise the care plan to reflect the resident's current status for one of three residents reviewed for ADL's (activities of daily living) (Resident #26) and one of three residents reviewed for nutrition (Resident #5). The findings included: 1. Resident #26 was admitted to the facility 6/28/13 and last readmitted 4/11/15. Cumulative	F 280	F280 For the resident found to have been affected by the alleged deficient practice, (#26 & #5), both residents were reassessed by our MDS coordinator on 12-2-15. Resident (#26) Restorative was removed from care plan and Resident (#5) Magic Cup was removed and ice cream was added to care plan on 12-3-15 by the MDS coordinator.	12/17/15

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F 280	Continued From page 4 diagnoses included, in part, dementia, osteoporosis, osteoarthritis and history of recurrent falls. A Quarterly Minimum Data Set (MDS) dated 10/14/15 indicated Resident #26 was moderately impaired in cognition. Limited assistance was required with transfers. She was independent with ambulation and locomotion in the room and off the unit. Mobility devices included wheelchair and walker. A care plan last reviewed and revised on 11/23/15 when Resident #26 sustained a fall revealed the following: Resident #26 had impaired mobility related to unsteady gait and arthritis in both arms. Approaches included: perform assisted/ active assisted range of motion exercises in all planes of movement for right upper extremity at 20 reps (repetitions) for 1 set, with 0-1 resistance, requiring cues assistance x 1 daily 6 x week. Perform bed transfers using walker with contact guard assistance. Perform commode transfers with walker with contact guard assistance daily 6 x week. It was noted all approaches would be done by the restorative aide. A review of the Restorative program indicated Resident #26 had been discharged from the restorative nursing program on 8/9/15 due to resident ambulating daily on her own and in her room. On 12/2/15 at 12:10PM, an interview was conducted with NA#1. She stated Resident #26 had been in the restorative program, had done well and had been discharged from restorative several months ago.	F 280	For those residents having the potential to be affected by the same alleged deficient practice, the MDS Nurse, DON and Clinical Supervisors will audit 100% of resident care plans and make necessary corrections as needed. The result of the audits showed that all care plans were up to date with no inaccuracies. Audits were completed on 12-17-15. The Dietary Manager, Social Worker, MDS Coordinator and Activity Coordinator were in serviced on 12-3-15 by MDS consultant on how to maintain an accurate plan of care by updating there section in the working care plan and how to review documentations in resident's charts and how to transfer that information into the working care plan. To assure that the alleged deficient practice does not reoccur, the following measures will be put into place. The Care Plan team which consist of Dietary manager, Social Worker, Clinical Supervisor, MDS Coordinator and Activity Coordinator will review five care plans a week for four weeks and five care plans monthly for four months for inaccuracy in care plan. The care plan team will compare residents chart information to the care plan, if any inaccuracy found on the care plan, corrections will be done immediately. The MDS coordinator will go over telephone orders in the morning nursing meetings daily and update the care plan per the physicians order. The MDS coordinator and DON will ensure that that care plan is updated within 72	

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F 280	Continued From page 5 On 12/2/15 at 12:22PM, an interview was conducted with the MDS nurse who stated she was in charge of the restorative program and also updated/ reviewed the care plans. She stated Resident #26 was no longer in restorative and the care plan should have been updated and the restorative program removed from the care plan at the time she was discharged from the restorative program. On 12/02/2015 at 2:34PM, Administrative staff #1 stated the care plan should reflect the resident's current status and the care plan for restorative nursing should have been resolved. 2. Resident #5 was initially admitted to the facility on 10/24/13 and was readmitted on 9/17/15 with multiple diagnoses including dementia. The admission Minimum Data Set (MDS) assessment dated 9/24/15 indicated the resident was cognitively intact. A review of Resident #5 ' s care plan dated 9/25/15 revealed the problem area of nutrition. The interventions stated that a magic cup (a fortified frozen dessert) was added to Resident #5 ' s lunch tray. An interview was conducted on 12/1/15 at 2:30 PM with the Dietary Manager (DM). He revealed the magic cup was discontinued for Resident #5. He was unable to locate the date that the magic cup was discontinued. An interview was conducted on 12/1/15 at 2:35 PM with the MDS nurse. She stated that she was responsible for revising care plans. She reviewed Resident #5 ' s care plan and consulted with the DM. She revealed that the care plan was	F 280	hours. The MDS coordinator will bring results of this audit to the QA meeting monthly for five months starting on 12-22-15. In order to monitor our performance and to make sure that these solutions are sustained, any care plan identified as inaccuracy will be brought to the QA committee monthly for five months by the MDS coordinator. The QA committee will make changes as needed if inaccuracy occur in the care plan during the five month period.	

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F 280	Continued From page 6 not accurate. She stated that she should have updated the care plan to remove the intervention for the magic cup for Resident #5.	F 280		
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. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to treat the open area and blister when first identified for 1 (Resident #39) of 1 sampled resident with a skin condition. Finding included: Resident #39 was originally admitted to the facility on 6/29/15 with diagnoses including multiple sclerosis and dementia. The significant change in status Minimum Data Set (MDS) assessment dated 10/30/15 indicated that Resident #39 had severe cognitive impairment and no other skin problems except for the stage 4 pressure ulcer. On 12/2/15 at 9:30 AM, Resident #39 was observed with NA #2 (assigned to the resident). The resident was observed to have an open area and a blister on her left groin. The open area and the blister had no dressing on them. The doctor's orders and the nurse's notes for November and December, 2015 were reviewed.	F 309	F309 For the resident found to have been affected by the alleged deficient practice, (#39), a skin assessment was performed by the wound nurse and treatment was applied to the blister area. For those residents having the potential to be affected by the same alleged deficient practice, the DON and Clinical Supervisors performed skin audits on 100% of residents in the facility. From these audits all skin conditions had proper treatments in place. There was one new skin condition identified in these audits and treatment was put in place as soon as skin condition was found. Completion Date: December 4, 2015 To assure that the alleged deficient practice does not reoccur, the following	12/17/15

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F 309	Continued From page 7 There were no treatment order or notes about the open area and the blister. The treatment administration record (TAR) for November and December, 2015 were reviewed. There were no documentation of treatment provided to the open area and the blister. On 12/2/15 at 9:35 AM, NA #2 was interviewed. She stated that she had noticed the open area and the blister last Monday (11/30/15). She revealed that the open area and the blister on the left groin were from the disposable brief that was too tight for the resident. NA #2 indicated that she changed the resident's disposable brief to a bigger size. NA #2 also indicated that she had informed Nurse #1 (treatment nurse) about the open area and the blister on 11/30/15. On 12/2/15 at 3:05 PM, Nurse #1 was interviewed. She stated that she was not informed of any new open area or blister on Resident #39. She went to observe the resident's left groin and found the open area and the blister. Nurse #1 measured the open area 0.7 x (by) 1.1 centimeter (cm) and the blister 0.4 x 1.0 cm. On 12/3/15 at 10:15 AM, administrative staff #1 was interviewed. She stated that she expected the nurse aide to inform the nurse/treatment nurse immediately when a skin problem was identified.	F 309	measures will be put into place. Full Time, PRN, and Weekend staff for all shifts were in serviced on addressing skin conditions as soon as they are recognized by staff. Also, the same staff were in serviced on our new Skin Communication book and applying treatment to skin conditions per our standing wound orders as soon as the wound is recognized. This in service was completed by the DON & Clinical supervisors on 12-7-15. Skin communication books were placed on each nursing wing. CNAs and Licensed staff will update daily on all shifts on any new skin conditions in the facility. The wound nurse and RN Supervisor will monitor these books daily and will assess and treat skin conditions within 24 hours. Licensed staff will complete weekly skin assessments on all residents starting the week of 12-7-15 and our Clinical Supervisors will audit skin assessments against the Skin Communication Book weekly for four weeks and monthly thereafter. In order to monitor our performance and to make sure that these solutions are sustained, any resident identified going forward will be discussed at the weekly Patient at Risk meeting which consist of, MDS coordinator, Dietary Manger, Administrator, DON, Clinical Supervisors and Wound Nurse and the Wound Nurse & Clinical Supervisors will be responsible for bringing any new skin conditions on all residents monthly to our QA meeting.	
F 314	483.25(c) TREATMENT/SVCS TO	F 314		12/17/15

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F 314 SS=D	Continued From page 8 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess a pressure wound accurately on the initial wound assessment and failed to consult with a wound physician when the wound did not improve (Resident #75). The findings included: 1. a. Resident #75 was admitted to facility 8/14/15 and discharged home 9/12/15. Cumulative diagnoses included: pressure ulcer of the sacrum. An admission nursing assessment dated 8/14/15 indicated Resident #75 had a sacral wound on bilateral buttocks that measured 4.8 centimeters long x 6.2 centimeters wide. There was no further description of the pressure wound. A review of the medical record revealed no admission nursing note with a description of the pressure wound. An Admission/ interim care plan dated 8/14/15 indicated Resident #75 had a stage 2 decubitus	F 314	F314 For the resident found to have been affected by the alleged deficient practice, (#75), no intervention was needed due to the resident being discharged on 9-12-15. For those residents having the potential to be affected by the same alleged deficient practice, the DON and Clinical Supervisors performed skin audits on 100% of residents to ensure that pressure sites were staged correctly. Audit was completed December 4, 2015. The results of the skin audits found that all wounds were staged correctly per Pinehurst Health Care & Rehabilitation Center wound policy. The wound nurse was in serviced on 12-3-15 by the DON on wound care protocol and she attended an online program on 12-2-15 with VOHRA to be certified as a wound nurse. All wounds in the building will be referred to the wound doctor.	

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F 314	Continued From page 9 ulcer to sacrum. A wound care assessment dated 8/17/15 stated a pressure ulcer on the sacrum was identified on 8/14/15 as a stage 2 pressure ulcer that measured 2.6 centimeters in length, 6.7 centimeters wide and 0.10 centimeters in length. The wound bed was noted as follows: epithelial tissue-- 30%, granulation tissue--20%, slough 50%. A stage 2 pressure ulcer is defined as a partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red, pink wound bed without slough. A stage 3 pressure ulcer is defined as a full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling. An Admission MDS dated 8/21/15 indicated Resident #75 was cognitively intact. Pressure ulcer: noted as yes, stage 3 pressure ulcer present on admission, measurements: 2.6 centimeters length x 6.7 centimeters width x0.1 centimeters depth with slough present. On 12/03/2015 at 8:53AM, Nurse #1 stated she was the wound care nurse. She stated, when she observed Resident #75's pressure ulcer during the initial assessment, she was unaware of the sloughing in relation to the accuracy of the staging. With the slough present, the pressure ulcer should have been a stage 3 pressure ulcer. Nurse #1 stated all further wound assessments correctly identified the pressure ulcer as a stage 3 pressure ulcer.	F 314	To assure that the alleged deficient practice does not reoccur, the following measures will be put into place. All wounds in the facility pressure or non-pressure except skin tears will be referred to the Wound Doctor weekly by the wound nurse which was started on 12-8-15. The wound nurse & weekend supervisors will review skin communication books daily starting 12-4-15. The wound nurse and weekend supervisor will review these books for any new open areas and will follow Pinehurst Health Care & Rehabilitation Center wound care protocol for her assessment. The wound nurse and weekend supervisor will complete their own skin assessments within 24 hours of resident's admission. Patient at Risk committee which consist of, MDS coordinator, Dietary Manger, Administrator, DON, Clinical Supervisors and Wound Nurse will compare VOHRA wound assessments and nurse assessments against the wound nurse assessments to ensure accuracy weekly which will start on 12-11-15. The results of this audit will be brought to QA by the DON. In order to monitor our performance and to make sure that these solutions are sustained, The DON will bring all open pressure sites and the results of our Patient at Risk committee meeting on the accuracy of our staging of these pressure sites. The DON will bring the results of our Patient at Risk committee meeting monthly starting on 12-22-15 and will continue monthly thereafter.	

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F 314	Continued From page 10 On 12/03/2015 at 10:05AM, Administrative staff #1 stated nursing staff should go by the wound protocol and, if slough tissue was present, the wound should have been staged as a stage 3 pressure ulcer. On 12/03/2015 at 10:41AM, Administrative staff #1 stated the wound care nurse made an honest mistake and incorrectly staged Resident #75's pressure ulcer as a stage 2 pressure ulcer and it should have been accurately staged as a stage 3 pressure ulcer. 1. b. Resident #75 was admitted to facility 8/14/15 and discharged home 9/12/15. Cumulative diagnoses included: pressure ulcer of the sacrum. An Admission MDS dated 8/21/15 indicated Resident #75 was cognitively intact. Pressure ulcer: noted as yes, stage 3 pressure ulcer present on admission, measurements: 2.6 centimeters length x 6.7 centimeters width x0.1 centimeters depth with slough present. A care plan dated 8/25/15 stated Resident 75 had a stage 3 pressure ulcer to sacrum and was at risk for further skin breakdown. Approaches included: Measure wound at least weekly. Report any decline in wound status to physician. A review of the wound care assessments revealed the following: 8/17/15-stage 2 sacral pressure ulcer identified on 8/14/15 with the following measurements: 2.6 centimeters in length, 6.7 centimeters wide and 0.10 centimeters in length. The wound bed was	F 314		

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	345370	A. BUILDING _____ B. WING _____	12/03/2015

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F 314	Continued From page 11	F 314		

noted as follows: epithelial tissue-- 30%, granulation tissue--20%, slough 50%.
8/25/15-stage 3 sacral pressure ulcer with the following measurements: 2.4 centimeters in length, 3.0 centimeters wide and 0.10 centimeters depth. The wound bed was noted as follows: epithelial tissue-10%, granulation tissue-40% and slough-50%.
9/1/15--stage 3 pressure ulcer with the following measurements: 2.8 centimeters in length, 2.4 centimeters wide and 0.10 centimeters depth. The wound bed was noted as follows: epithelial tissue-- 20%, granulation tissue-- 20% and slough-- 60%.
9/9/15-- stage 3 pressure ulcer with the following measurements: 2.6 centimeters in length, 2.3 centimeters wide and 0.10 centimeters depth. The wound bed was noted as follows: epithelial tissue--10%, granulation tissue--30% and slough-60%.

A review of the medical record for Resident #75 revealed there was no physician's order for Resident #75 to be seen by the wound doctor when the pressure ulcer increased in slough tissue from 50% to 60%.

On 12/3/15 at 8:53AM, Nurse #1 stated she was the wound care nurse. She stated she was responsible for notifying the wound care doctor of any wounds that needed to be seen by him. Nurse #1 stated Resident #75 was not seen by the wound care physician and she could not recall why he was not referred to the wound care doctor for evaluation and treatment of the sacral pressure ulcer.

On 12/03/2015 at 10:05AM, Administrative staff #1 stated the wound doctor usually saw all the

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F 314	Continued From page 12 wound in the building and Resident #75 should have been seen but the wound doctor weekly. On 12/03/2015 at 10:41AM, Administrative staff #1 stated Resident #75 was not seen by the wound doctor. She stated it was a nursing decision because they did not want the wound care doctor to surgically debride the wound. Administrative staff #1 stated all residents with wounds were seen by the wound doctor and Resident #75 should have been referred/ seen by the wound doctor.	F 314		
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: Based on record review, observation and staff interview, the facility failed to apply the wash cloth to bilateral hands as care planned for 1 (Resident #2) of 2 sampled residents with contractures. Findings included: Resident #2 was originally admitted to the facility on 2/27/96 with multiple diagnoses including cerebrovascular accident (CVA) with hemiplegia. The quarterly Minimum Data Set (MDS) assessment dated 9/24/15 indicated that Resident #2 had memory and decision making	F 318	F318 For the resident found to have been affected by the alleged deficient practice (#2), Occupational therapy assessed resident on 12-2-15 and a palm protector was applied to her right hand. Resident was referred to restorative on 12-4-15 for PROM to Bilateral upper and lower extremities six times a week to maintain current ROM.	12/17/15

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F 318	Continued From page 13 problems and had functional limitation in range of motion on both sides of upper and lower extremities. The assessment further indicated that the resident did not receive assistance with ROM or splint/brace during the assessment period. The assessment also indicated that the resident did not exhibit a behavior of rejection to care. The care plan dated 9/25/15 was reviewed. The care plan approaches included " place rolled wash cloths in bilateral hands as she will allow. " The nurse's notes for October, November and December, 2015 were reviewed. The notes did not have documentation that Resident #2 had resisted care or refused care. On 11/30/15 at 2:38 PM, interview with Nurse #2 revealed that Resident #2 had contractures on her hands and was not receiving a splint or range of motion exercise. On 11/30/15 at 5:13 PM, Resident #2 was observed with contracture on her hand. There were no hand roll or rolled wash cloth noted on her hands. On 12/1/15 at 3:45 PM and 12/2/15 at 8:45 AM, Resident #2 was observed. There was no hand roll or rolled wash cloth observed on her hands. On 12/2/15 at 2:15 PM, NA #3 (assigned to Resident #2) was interviewed. NA #3 stated that if the resident was on a splint/hand roll it should have been written on the resident's kardex. The kardex for Resident #2 was reviewed. The hand roll/rolled wash cloth was not written on the kardex. On 12/2/15 at 2:50 PM, the MDS Nurse was interviewed. She stated that Resident #2 had not been screened by the therapy department since 2013. On 12/2/15 at 3:55 PM, the therapy director was interviewed. She stated that Resident #2 had not	F 318	For those residents having the potential to be affected by the same alleged deficient practice, the DON and Clinical Supervisors performed contracture audits on 100% of residents, to ensure that all residents with contractures had interventions in place. The result of this audit showed that all residents had proper interventions in place and residents identified with contractures were receiving ROM exercises. The DON and Clinical supervisors inserviced all CNAs and license nursing staff, fulltime, part-time, PRN and weekend staff by 12-7-15 on how to recognize and who to inform of any old or new contractors. All license staff and CNAs are required to inform the DON, Clinical supervisors or weekend supervisor daily on any worsening or new contractor in the facility. To assure that the alleged deficient practice does not reoccur, the following measures will be put into place. The therapy manger and her team will review residents that are due for upcoming MDS assessments to screen for ROM deficits and any new contractures quarterly. Residents that have been reported to the DON, Clinical Supervisors or Weekend supervisors for worsening or new contractors will be assessed and treated by the Therapy Team at that time. Therapy department will refer to restorative program if needed. The MDS coordinator will audit weekly for eight weeks and monthly for four months through her assessments to ensure that all residents with contractures are	

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F 318	Continued From page 14 been screened since 2013 because the therapy department thought that Resident #2 was on hospice. Normally, residents were screened quarterly and as requested due to changes in condition. She added that she did not know that the resident was discharged from hospice last year 2014. On 12/2/15 at 4:05 PM, the occupational therapist (OT) was interviewed. She stated that she will evaluate and treat Resident #2 for orthotic/splint management for the contracture.	F 318	receiving treatment for those contractures. In order to monitor our performance and to make sure that these solutions are sustained, The MDS Nurse will bring results of her audits monthly to our QA committee meeting. Next QA meeting will be on 12-22-15.	
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 and correct quality deficiencies will not be used as a basis for sanctions.	F 520		12/17/15

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F 520	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to implement and monitor the action plan developed during the recertification survey dated 1/8/15 in order to achieve and sustain compliance in the area of Minimum Data Set (MDS) assessments. Accuracy in MDS assessment was cited again on the current recertification survey of 12/3/15. The findings included. This tag is cross referenced to: F278 - Resident Assessments - Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment on radiation and chemotherapy treatment, range of motion exercises and splinting and the use of psychotropic medication for 2 (Resident #39 & # 99)of 20 sampled residents reviewed. During the recertification survey of 1/8/15, the facility was cited F278 for failing to accurately code the MDS assessment for the use of psychotropic medication and weight. On 12/3/15 at 10:45 AM, administrative staff #2 was interviewed for quality assessment and assurance (QAA). He stated that the QAA committee had met monthly and quarterly. He further indicated that he was aware that MDS accuracy was cited last year but the staff had not been monitoring it.	F 520	F520 For the residents found to have been affected by the alleged deficient practice, (#39, #99), MDS correction was submitted on 12-2-15 by the MDS Nurse. For those residents having the potential to be affected by the same alleged deficient practice, the MDS Nurse will audit 100% of resident assessments to determine that any restorative, radiation and chemotherapy and psychotropic medication have been properly assessed by 12-14-15. To ensure that this alleged deficient practice does not reoccur, the following measures will be put into place. The MDS coordinator was in serviced on 12-3-15 by MDS Consultant, the in service included the facility procedures on coding MDS assessments, RAI manual review and coding from all documentation in residents chart. The Patients at Risk committee which meets weekly on Wednesdays consist of, MDS coordinator, Dietary Manger, Administrator, DON, Clinical Supervisors and Wound Nurse. The Patients at Risk committee will review five MDS assessments weekly for four weeks and five MDS assessments a month for four months alternating different residents in each MDS assessment review period, starting on 12-11-15. The Patient at Risk committee will be reviewing accuracy of	

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F 520	Continued From page 16	F 520	the MDS assessments by auditing the Medication Administration Record, Treatment Administration Record, Restorative Flow Sheets, ADL flow sheets, Nursing Notes, MD orders & Visits, Therapy, Wound nurse assessments and Vohra assessments. The DON will record findings of inaccuracy of the MDS assessments and the MDS coordinator will correct the inaccurate MDS assessment before transmission. This information will be recorded on a MDS assessment tracking sheet and brought to our monthly QA meeting by the DON. In order to monitor our performance and to make sure that these solutions are sustained, the DON will bring all audit results to the QA committee meeting monthly for five months. The QA committee will review any inaccurate MDS assessments and will provide in services as needed or change the current monitor system.	