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	345321	A. BUILDING _____ B. WING _____	04/28/2016

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F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews and record reviews, the facility failed to identify medical symptoms that warrant the use of physical restraints and failed to implement systematic approaches to reduce restraints for 4 of 5 sampled residents (Resident #1, Resident #85, Resident #150 and Resident #2). The findings included: 1). Resident #1 was admitted on 4/9/96. The cumulative diagnoses included quadriplegia, cerebral palsy and seizure disorder. The quarterly Minimum Data Set (MDS) dated 3/22/16, revealed Resident #1 required total assistance with activities of daily living. The annual MDS dated 12/22/15, did not code Resident #1 as a restraint. Review of the initial physician 's order dated 7/27/04 and most recent 9/18/13 read: lap buddy to wheelchair when out of bed as a restraint due to quadriplegia and seizures and lap tray to geri-chair when out of bed as an enabler due to quadriplegia and seizures. Review of the physical restraint evaluation form dated 5/22/08, read: the lap buddy was used in wheelchair to maintain proper trunk alignment	F 221	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F221 Right to be free from physical restraints 1. Corrective action for the residents affected Resident # 1 was referred to therapy on	5/23/16

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

Electronically Signed | 05/23/2016

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F 221	Continued From page 1 and pelvic position and lap tray used in ger-chair for activities. The lap buddy was to be used when out of bed and accompanied by family. Will use both lap buddy and lap tray as enabler due to resident inability to rise in chair or walk. The devices will be used as a positioning devices as well as safety. There were no further evaluations after 2008. Review of the care plan dated 3/24/16, identified the problem as the resident required assistance to maintain maximum function of self-sufficiency for mobility characterized by the following functions; positioning related to lack of limb/trunk control due to cerebral palsy, and quadriplegia. The goal included the resident would maintain upright posture. The approach included mobility with minimum physical assistance in wheelchair with lap buddy as enabler and constant supervision while up in wheelchair. During an observation on 4/26/16 at 10:26AM, Resident #1 was escorted into the dining area for an activity with the lap buddy in place. Resident #1 was able to propel the wheelchair with his feet. Resident #1 sat in an upright position and was able to reposition self in wheelchair with verbal cues by pushing hips back into wheelchair. During an observation on 4/26/16 at 1:40PM, Resident#1 was in his room seated in the geri-chair without the lap tray in place watching television. The resident did not demonstrate any positioning concerns while seated in the geri-chair. During an observation on 4/27/16 at 10:30AM, Resident #1 propelling self in wheelchair with lap buddy in place and family member following	F 221	4/27/16 by the QI Nurse for evaluation for positioning in chair and is currently receiving Therapy to assist with identifying appropriate chair/device to enable resident to sit upright and prevent sliding when out of bed in chair. A reduction attempt was conducted by the Occupational Therapist on 5/20/16 and was unsuccessful as resident exhibiting unsafe behaviors leaning forward in chair and requires contact guard assist to regain upright position and scooted forward in chair and required verbal and tactile cues for safety to sit properly in chair. A new Physical Restraint Evaluation was completed by the QI Nurse on 5/20/16 showing that a velcro seat belt remains the least restrictive device for resident # 1 while out of bed in W/C at this time. The Physical Restraint for Resident # 150 was discontinued on 5/20/16. The physical restraint for Resident #2 was discontinued on 5/4/16. Resident # 85 no longer resides at this facility. 2. Corrective action for residents having the potential to be affected 100% audit, using a resident census, was completed on 5/2/16 by the MDS Nurse for all residents requiring the use of physical restraints to include resident #1, resident # 150, resident #2, and resident #85 to ensure appropriate medical symptoms had been identified to warrant physical restraint use and the least restrictive physical device is currently being utilized. Any identified concerns were immediately addressed by the ADON and MDS Nurse by conducting physical restraint reductions and	

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F 221	Continued From page 2 behind resident throughout the facility. The family member giving verbal cues to reposition self in chair and resident was able to push himself up to the back of the chair using his feet and leaning on one side of arm rest to push backward into chair. During an interview on 4/27/16 at 10:45AM, the MDS Nurse#1 indicated that the resident ' s lap buddy was coded on MDS as an enabler because the device was used for safety and fall prevention and not a restraint. During an observation on 4/27/16 at 2:00PM, resident in room in geri-chair without lap tray in place watching television. Resident #1 had not difficulty with movement while seated in geri-chair. During an interview 4/27/16 at 2:37PM, the Assistant Director of Nursing (ADON) indicated Resident #1 used the lap buddy when the responsible was present due to the resident propelling self in wheelchair around the building and the responsible person could not keep up with him, therefore he was to wear it during her visits to prevent injuries and for his safety. She further stated the responsible person was always present when the lap buddy was in place. The lap tray for the geri- chair was for activities when the resident was in the room. She further the lap buddy was to prevent the resident from leaning forward. She indicated there had not been any further assessment or coding on the MDS to indicate the lap buddy as a restraint because it was used as an enabler. During a follow-up interview on 4/27/16 at 3:52PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON), stated the	F 221	completion of new Physical Restraint Evaluations for those residents for whom physical restraints could not be reduced. Residents with enablers were reevaluated by the MDS Nurse on 5/2/16 to ensure the device in use did not meet the CMS definition of a physical restraint. Any device determined to meet the CMS definition of a physical restraint had a Physical Restraint Evaluation completed, an order obtained from the physician for restraint use, and resident care plan and care guide updated to reflect the use of a physical restraint by the QI Nurse by 5/20/16. 3. Measures put into place or systemic changes made to ensure the deficient practice does not reoccur The ADON was inserviced regarding the CMS definition of a physical restraint, identifying medical symptoms that warrant physical restraint use, and the need to attempt periodic reduction of physical restraints per protocol on 5/17/16 by the Facility Consultant. A 100% inservice of all nursing staff, to include the MDS Nurse #1, MDS #2, NA #3, NA #4, NA #5, NA # 6, and the Administrator was conducted by the DON and ADON on CMS regulations regarding the use of physical restraints/ enablers and the need to report changes in resident condition to ADON or DON that may warrant a physical restraint/enabler change or reduction. Inservicing to be completed by 5/19/16. All newly hired CNAs and licensed nursing staff will be educated on CMS regulations regarding the use of physical restraints/	

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F 221	Continued From page 3 indicated the use of the lap buddy was for seizures, quadriplegia and cerebral palsy. The ADON indicated that no other type of device was attempted for positioning in several years. The lap buddy was put in place to prevent the resident from leaning forward, falling and safety measures. The DON indicated she could not recall when therapy had last seen the resident for positioning. The lap buddy was not assessed as a restraint but as an enabler. During an interview on 4/27/16 at 4:20PM, the responsible person (RP) stated she did not want the lap buddy removed because the pillow (lap buddy) helped the resident sit in an upright position. The responsible person indicated if the lap buddy was removed she could not handle the resident if he fell on the floor during their visits within the facility. The RP stated that she requested the use of the lap buddy for the resident's safety. During an interview on 4/27/16 at 4:45PM, the Administrator indicated that the lap buddy was in place for the resident as an enabler and to prevent falls, leaning and safety. She further stated that the resident's family wanted the use of the lap buddy for safety when he was propelling around in the facility when RP was present because she would be unable to handle the resident should he slide out of the chair. She further indicated the lap buddy was only used when family was present, there was no response as to why the device was not necessary during other times of the day when resident was up. In addition, the administrator stated she was unaware of any other devices used or restraint reduction attempts.	F 221	enablers and need to report changes in resident condition to ADON/ QI Nurse or DON that may warrant a physical restraint/enabler change or reduction during the orientation process by the DON, ADON/ QI Nurse, or Staff Facilitator. 4. How the facility plans to monitor the measures to make sure solutions are sustainable When considering the implementation of a physical restraint or enabler, the members of the Physical Restraint Committee, to include the ADON/QI Nurse, MDS Nurses, DON, and the Administrator will review the resident□s clinical record to ensure alternative interventions have been attempted and that the resident has identifiable medical symptoms to justify the use of the physical restraint or enabler. Once a physical restraint or enabler is initiated, the members of the Physical Restraint Committee will review the use of the restraint quarterly and enabler monthly and attempt reductions as per protocol to ensure the device remains the least restrictive. Residents requiring the use of physical restraints or enablers, to include resident # 1, and will be reviewed using a Physical Restraint QI Audit Tool and an Enabler QI Audit Tool by the First Shift Patient Care Coordinator, Staff Facilitator or MDS Nurses to ensure the device remains least restrictive weekly x 4 weeks, every 2 weeks x 4 weeks, then monthly x 2 months. The Physical Restraint QI Audit Tool and Enabler QI Audit Tool will be reviewed and initialed by	

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F 221	Continued From page 4 2) Resident #85 was admitted to the facility on 2/14/14. The cumulative diagnoses included dementia, seizures and hypertension. The quarterly Minimum Data Set (MDS) dated 2/2/16 indicated the resident required total assistance with all activities of daily living. Review of the previous physician 's order dated 12/8/15, read: positioning vest to wheelchair when out of bed as physical restraint due to kyphosis. The new order dated 2/19/16, read: to discontinue the click it seat belt to wheelchair and start click it seat belt to geri-chair when out of bed as restraint due to kyphosis and poor sitting posture. Review of the restraint evaluation done 2/19/16, documented the medical symptoms as kyphosis and poor sitting posture. During an observation 4/25/16 at 12:30PM, Resident #85 was seated by the nursing station with blue seat belt in place sitting in an upright calm position. There were no repetitive movements in any direction. Resident #85 also had support cushions in place on both side of the chair. During an observation on 4/26/16 at 10:09AM, Resident#85 was in the dining room for an activity. The resident was seated in a high back geri-chair with side cushions and a blue seat belt. Resident#85 was observed sleep in the geri-chair sliding down with the belt up above breast level. Assistance was requested of two staff to reposition resident back into chair due to the location of the restraint. Resident #85 unable to release restraint or reposition self. However, once staff awakened resident and reposition her she	F 221	the Administrator or DON weekly x 4 weeks then every 2 weeks x 1 month then monthly x 2 months to ensure compliance. The Administrator will compile the results of the QI Physical Restraint Audit Tool and the Enabler QI Audit Tool and present to the Executive QI Committee monthly x 4 months to determine the need for and/ or frequency of continued monitoring, recommendations for monitoring and continued compliance.	

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sat in the chair without any difficulty. The resident drifted back in an out of sleep throughout the activity. Resident #85 made no attempt to lean forward, get out of chair or any excessive sliding during the observation.

During an interview on 4/26/16 at 1:57PM, MDS Nurse #2 indicated Resident #85 click seat belt was in place due to kyphosis and poor sitting posture. There were no falls identified within the last MDS Nurse#2 confirmed the resident was unable to release the seat belt.

During an observation on 4/26/16 at 2:45PM, Resident #85 was in the dining room for an activity sleeping. The seat belt at above breast level as resident slept in geri-chair. Resident#85 did not exhibit any repetitive movements and was able to slightly reposition self when startled by her own snoring.

During an observation on 4/27/16 at 8:55am, Resident #85 ate her meal with restraint in place.

During an interview on 4/27/16 at 10:45AM, MDs#1 indicated that the resident was coded on the Minimum Data Set (MDS) as restraint. The seat belt was used to prevent the resident from falling from the chair.

During an interview on 4/27/16 at 2:05PM, the Assistant Director of Nursing (ADON) indicated that click it seat belt was used due to kyphosis and leaning forward.

During an observation on 4/27/16 at 2:29PM, Resident #85 was asleep in her room in the geri-chair with seat belt in place. The resident was seated in an upright position with the side

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cushions in place. There was no physical movements or sliding present.

During an interview on 4/27/16 at 3:15PM, the Administration indicated that the family was actively involved and a vest restraint was used during meals to prevent her from leaning forward. The family did not like the use of the vest so the click it seat belt was added to the geri-chair to prevent the resident from falling and leaning forward.

During an observation on 4/28/16 at 8:30AM, Resident#85 was seated in dining room being assisted by staff with the meal. The seat belt was in place during the entire meal. The resident was sleep for most of the meal and verbal cues were used to wake her up to eat. The resident had no physical movements in either direction or made any attempts to exit the chair or slide.

During an interview on 4/28/16 at 8:30AM, the nursing assistant (NA#5) indicated that the resident slept a lot and would slide down in the chair when she was sleepy. NA#5 indicated that when she saw the resident sleeping a lot she would put the resident to bed. She indicated the belt was used to prevent the resident from sliding down in the chair.

3). Resident#150 was admitted on 3/31/16. The cumulative diagnoses included cerebral infarction, hypertension and altered mental. The Minimum Data Set (MDS) dated 4/12/16. The resident required assistance with all activities of daily living. The MDS coded the seat belt as a restraint.

Review of the physician's order dated 4/11/16,

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read: click it seat belt when out of bed due to unsafe transfers.

Review of the care plan dated 4/22/16, identified the problem as: use/application of physical restraint device for prevention of injury to self or others characterized by high risk for injury/falls, impaired mobility, physical aggression related to unsteady gait and unsafe transfers. The goal included the resident would not fall thru next review. The approach included and evaluation of a device for least restrictive, reduction and/or discontinuation per facility.

Review of the Quality Improvement- Physical Restraint/Enabler Review form dated 4/26/16, read as follows: Resident has a history of falls, impaired cognition, and a diagnosis of cerebral infarction, and AMS (altered mental status). He currently used a click it seat belt to wheelchair when out of bed as a physical restraint due to unsafe ambulation. The resident tolerated it well and will continue with current plan of care.

During an observation on 4/28/16 at 2:50PM, Resident#150 was seated in his room with blue click it seat belt in place. Resident#150 's cognition was impaired and he was unable to remove the belt. Resident #150 sat in an upright position without and difficulty or leaning in any direction in the wheelchair. He did not demonstrated any physical/repetitive movements in any direction.

During an interview on 4/28/16 at 2:50PM, NA#6 indicated that resident wore the seat belt because he tried to get up, he just kind of pushes up on the armrest, never seen him actually stand but made the attempts.

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During an interview on 4/28/16 at 3:10PM, the Director of Nursing (DON) indicated that the medical justification for the use of the click seat belt was unsafe transfers. She further stated that resident would be reviewed for potential reduction and/or elimination.

4) Resident #2 was admitted on 11/1/98 from the hospital. Her cumulative diagnoses included Alzheimer ' s disease and hemiplegia (paralysis of one side of the body).

A review of the resident ' s medical record revealed a physician ' s order dated 4/23/13 read: " Velcro seatbelt while sitting up in geri-chair as an enabler for safe positioning. "

A review of Resident #2 ' s electronic medical record included a Quality Improvement narrative under the heading of " Physical Restraint/Enabler Review " for each of the following dates: 7/16/15, 8/31/15, 10/16/15, 11/30/15, 12/22/15, 1/29/16, and 2/29/16. Each narrative reported the resident had a diagnosis of hemiplegia, leaned to the right, and utilized a Velcro seatbelt while in a geri-chair as an " enabler. " Each narrative also indicated the plan of care would be continued.

A review of Resident #2's Care Guide (dated 3/8/16) placed on the inside of her closet door was completed. The Care Guide provided instructions to put the resident in a geri-chair with a Velcro seatbelt applied when she was out of bed.

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The resident ' s most recent quarterly Minimum Data Set (MDS) dated 3/11/16 indicated Resident #2 was assessed by staff as having severely impaired cognitive skills for daily decision making. The resident required extensive assistance for bed mobility, locomotion, dressing and personal hygiene; she was totally dependent on staff for transfers, eating, and toileting. There were no reports of falls occurring since the last assessment. Resident #2 was not coded as having a trunk restraint used within the 7 day look back period.

A review of Resident #2 ' s Care Plan dated 3/15/16 included the following:
Problem/Need: Requires assistance to maintain maximum function of self-sufficiency for mobility characterized by the following functions; positioning related to left hemiparesis, safe positioning due to leaning (revised on 4/24/13).
Goal: Will maintain upright posture through next review (revised on 11/18/11).
Interventions implemented to achieve the established goal included: " Dependent in geri-chair with Velcro seatbelt as an enabler " (revised on 4/24/13).

A review of Resident #2 ' s electronic medical record included a Quality Improvement narrative under the heading of " Physical Restraint/Enabler Review " as follows:
3/17/16 Quality Improvement- Physical Restraint/Enabler Review
" Data: (Resident #2) has impaired cognition. She has a diagnosis of Hemiplegia and leans to right.
Action: Velcro seatbelt to geri-chair due to hemiplegia as enabler.
Response: Tolerates well continue with plan of

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care. "

On 4/27/16 at 11:38 AM, Resident #2 was observed sitting in a geri-chair as she was wheeled out to the Dining Room by a Nursing Assistant (NA). The geri-chair was reclined back with the foot rest up. She had a blanket over her lap.

An interview was conducted on 4/27/16 at 11:40 AM with NA #3. NA #3 was the nursing assistant assigned to care for Resident #2. NA #3 reported a Velcro seatbelt was used for the resident whenever she was up in her wheelchair. The NA stated the resident did require a pillow at times to help with positioning if she leaned over. When asked what purpose the seatbelt served for the resident, the NA stated, "To keep her from falling out ...but she really don't move."

An observation was made of the resident sitting in the geri-chair in her room on 4/27/16 at 1:58 PM. The foot rest was elevated and a Velcro seatbelt was observed to be in place across the resident ' s lap. Resident #2 did not respond when spoken to.

An observation was made on 4/27/16 at 2:24 PM as Resident #2 appeared to be asleep in the geri-chair in her room. The resident was observed to be leaning towards her right side. A blanket was placed over the resident ' s lap. No lateral supports were in place for the resident at the time of the observation.

An interview was conducted on 4/27/16 at 3:15 PM with the facility ' s Assistant Director of Nursing (ADON). The Director of Nursing (DON) accompanied the ADON to the interview. Upon

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(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
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inquiry, the ADON reported she assumed responsibility to assess Resident #2 every month due to the use of the Velcro seatbelt. The ADON stated resident had a history of stroke and hemiparesis; she stated the Velcro seatbelt was an enabler, not a restraint. When asked what the Velcro seatbelt enabled the resident to do, the ADON stated it allowed her to sit upright in a chair without leaning either forward or to the side. The ADON reported she conducted a monthly Quality Improvement (QI) review and charting for enablers and restraints. She indicated the Velcro seatbelt used for Resident #2 was coded as an enabler. At the time of the interview, the ADON stated she talked with the resident's family member on 4/26/16 about taking another look at the use of a seatbelt for Resident #2 and he was fine with it. Upon inquiry, both the ADON and DON acknowledged a Therapy Department was available within the facility and could be utilized for restraint reduction advice and assistance. However, the ADON and DON reported this service not been utilized for Resident #2. Upon inquiry, the ADON and DON reported the resident could not remove the Velcro seatbelt by herself. The observation made of Resident #2 leaning to her side with the seatbelt in place was then discussed with ADON and DON. The DON reported she would ask Occupational Therapy to assess Resident #2 for possible lateral supports to assist with positioning.

A follow-up interview was conducted on 4/28/16 at 9:50 AM with the DON. During the interview, inquiry was made as to how an enabler could be differentiated from a restraint. The DON replied that a restraint would prevent a resident from getting up or touching part of his/her body whereas an enabler didn't prevent the resident

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from doing these things. Alternatively, a device could be termed an enabler if the resident could " undo it " him/herself. When asked, the DON confirmed Resident #2 could not undo the Velcro belt herself. However, the DON stated she felt the seatbelt used for Resident #2 was an "enabler" because it didn't prevent the resident from getting up or touching part of her body.

An observation of Resident #2 was made on 4/28/16 at 10:05 AM as she sat in a reclined geri-chair in her room; her feet were elevated and a blanket was laid across her lap. On 4/28/16 at 10:10 AM, Nurse #5 was asked to lift the blanket lying on the resident ' s lap. A Velcro seatbelt was observed to be secured across the resident ' s lap. Upon inquiry, the nurse stated a Velcro seatbelt had been used for Resident #2 as long as she had been at facility (about 3 years). When asked, Nurse #3 reported the resident could not remove Velcro seatbelt by herself.

An observation was made of Resident #2 sitting in the geri-chair in her room on 4/28/16 at 11:20 AM. The Velcro seatbelt was not in place; a pillow was placed under the resident ' s right arm. The resident was sitting straight in the chair without leaning to one side.

An interview was conducted on 4/28/16 at 11:25 AM with NA #4. NA #4 was assigned to care for the resident. Upon inquiry, the NA reported she had worked on the resident ' s hall for approximately 2 months. When asked, NA #4 stated she did not apply the Velcro seatbelt for the resident when she worked. The NA stated, "She doesn't need it...she doesn't move." NA #4 reported that when she worked, she made sure the resident was sitting all the way back in the

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geri-chair and would place a pillow on her right side for better positioning. The NA reported the resident did " fine " without the seatbelt. When asked if she had applied the Velcro seatbelt to the resident that morning, the NA reported she had not and thought someone else must have.

An interview was conducted on 4/28/16 at 11:50 AM with the facility ' s Occupational Therapist (OT). During the interview, the OT reported she had evaluated the resident earlier in the day and stated, "Good catch." The OT reported the resident did not have a seatbelt on when she was evaluated. When asked if there were any benefits to the use of a seatbelt for this resident, the OT stated, "Not really...not if the right lateral supports are used." The OT stated she would be "picking up" this resident and monitoring her for improved positioning.

An interview was conducted on 4/28/16 at 1:30 PM with Resident #2's family member. Upon inquiry, the family member stated he told the facility at least a year ago that the resident did not need a seatbelt. However, the family member stated he was told by someone at the facility that a seatbelt was required to be in place whenever she was up in the chair (except when she was eating). The family member indicated if the resident was positioned well in the geri-chair, she wouldn ' t lean to the side. He stated, "The belt really doesn't do anything."

A follow-up interview was conducted on 4/28/16 at 5:19 PM with the facility ' s DON. Upon inquiry, the DON discussed the process of reviewing a physical restraint. The DON reported if a device was no longer considered an enabler and became a restraint, she would expect a new

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F 221	Continued From page 14 physician ' s order to be obtained, a restraint evaluation to be done, the care plan and care guide to be updated, and the MDS nurses to schedule an assessment for a significant change in the resident ' s condition.	F 221		
F 253 SS=E	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, record reviews, staff and resident interviews the facility failed to have floors within the facility free from stains, cracks and an accumulation of brown colored substances in the floor corners; failed to repair peeling or torn walls; failed to repair partially detached window screens and remove the build-up of cobwebs; failed to repair and replace an outlet cover over the electrical wall socket. This was evident in 7 of 7 nursing units (Satterwhite Point, Henderson Point, Hibernia, NutBush, Island Creek, Williamsboro and Meekins Landing) Findings included: 1.a. Observation on 4/25/16 at 8:52 AM revealed multiple cracked floor tiles in the elevator located across from Room #236. The floor tiles also had an accumulation of a dark brown colored substance in the corners. There was a yellow colored strip of paper on the floor. The tracks of the elevator had an accumulation of a black colored substance and dust.	F 253	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal	5/23/16

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F 253	Continued From page 15 Observation on 4/25/16 at 12:35 PM revealed the condition of the elevator remained unchanged. Observation on 04/26/2016 at 9:00AM revealed the condition of the elevator remained unchanged. Observation on 04/26/2016 at 10:41AM revealed the elevator continued to remain unchanged. Interview on 4/27/16 at 3:00 PM with the housekeeping (HK) supervisor revealed he did not have enough staff to perform the housekeeping duties as assigned but has hired additional people. An inquiry was made about who was assigned to clean the elevator. The HK supervisor indicated he was assigned on 4/25/16, 4/26/16 and 4/27/16 to clean the elevators but was unable to clean because he was performing a different task and did not reassign the cleaning duty of the elevator to another housekeeper. Observation of the elevator on 4/28/16 at 3:45 PM with the Administrator and District Manager (DM) for the housekeeping services was done. The DM was able to remove some of the accumulation of the brown colored substance from the floor corner. b. Observation on 4/25/16 at 9:30 AM revealed the entrance to Room #236 had missing floor tiles. There were also missing floor tiles in the hallway across from Room #236. c. Observation on 4/26/16 at 11:20 AM in the bathroom shared by rooms #119-121 revealed missing floor tile. The corners of the floor had an accumulation of a brown colored substance. Continued observation on 4/26/16 at 11:20 AM revealed in the bathroom shared by rooms #119-121 revealed the wall behind the toilet bowl had a dried brown colored substance. d. Observation on 4/26/16 at 3:29 PM revealed	F 253	proceeding. F253 Housekeeping/ Maintenance Services 1. Corrective Action Elevator, to include elevator tracks, across from room 236 was deep cleaned by housekeeping to removed accumulation on 5/2/16 and cracked floor tiles in elevator replaced by 5/20/16. Bathroom between #119-121, #118, #220-222, #228-230, and second floor hall bath deep cleaned by housekeeping on 5/12/16 to remove build up and stain. Build up at corners to entrance to room 237 removed by housekeeping on 5/12/17. Red colored stains at entrance to rooms 242, 239, 238 removed by housekeeping 5/10/16. Bathroom ceiling light globe in room 236 cleaned by housekeeping 5/11/16. The Terrazzo Flooring in the doorway of 236 and across from 236 was repaired by maintenance staff by 5/20/16. Cove molding outside of room 232 was replaced by maintenance staff on 5/18/16. The cracked floor tile in the bathroom between room #228 and 230 was replaced by maintenance staff by 5/20/16. The Exit door on first floor near the elevator was cleaned and painted by maintenance staff by 5/20/16. Wall area at head of bed in room 122B repaired by maintenance staff by 5/20/16. Ceiling tile in room 234 was replaced by maintenance staff by 5/20/16. The hole in the bathroom wall of room 234 was repaired by maintenance staff by 5/20/16. Peeling paint was removed from room 120 B near the heating/ AC unit by maintenance staff by 5/20/16. New	

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F 253	Continued From page 16 the bathroom floor tiles in room #118 had multiple black colored stains. e. Observation on 4/27/16 at 11:00 AM revealed the corners of the entrance to room #237 had a build-up of a brown colored substance. f. Observation on 4/27/16 at 11:15 AM in Rooms #242, #239, and #238 revealed floor tiles with red colored stains. g. Observation on 4/27/16 at 11:20 AM revealed missing floor tile around the base of the toilet in room #236. The bathroom ceiling light globe contained an accumulation of debris. h. Observations on 4/27/16 at 11:30 AM revealed floor corners of the bathroom shared by rooms #220-#222 had an accumulation of a black colored substance. i. Observation on 4/27/16 at 11:55 AM revealed missing cove molding in the hallway outside Room #232. j. Observation on 4/27/16 at 12:10 PM in the bathroom shared by Rooms #228 -230 revealed cracked and missing floor tile. The corners of the floor tiles had an accumulation of a brown colored substance. k. Observation on 4/27/16 at 12:25 PM of the " Hall Bath " located on the second floor revealed the accumulation of a brown colored substance in floor corners and entrance way. l. Observation on 4/25/16 at 9:40 AM revealed the exit door on the first floor near the elevator revealed multiple thick black streaks on a light colored door. Interview on 4/27/16 at 1:50 PM with housekeeper (HK) revealed her functions were to sweep, mop and deep clean rooms three times a week. The HK indicated it was not her responsibility to clean the floors.	F 253	wardrobe was placed in room 120 by maintenance staff on 5/18/16. The wall behind the door in room 222 was repaired by maintenance by 5/20/16. In Room 204 the chipped paint was repainted and the cove molding was replaced by 5/20/16 by maintenance staff. Peeling paint on the door frame of the second floor dining room was removed and repainted by 5/20/16 by maintenance staff. Cobwebs and debris were removed from outside of the windows of rooms 102, 220, 222, 224 and second floor dining room by 5/20/16 by the housekeeping staff. Window screens removed/ repaired rooms 102, 220, 224, 228 and second floor dining room by maintenance staff by 5/20/16. Face plate on electrical sockets in room 204 and 120B replaced by maintenance staff on 5/13/16. The wall radiator vent near the elevator was repaired by 5/20/16 by maintenance staff. The bathroom sink between rooms 120-122 was repaired to freely drain on 5/15/16 by maintenance staff. 2. Corrective Action for the residents having the potential to be affected 100% audit of all resident rooms and halls for buildup of accumulation on floor, in corners, stains on floors, missing cove molding and tile, holes in walls, peeling paint, streaks on doors, cobwebs and debris on outside windows, window screens needing repair was completed by 5/6/16 by the administrator. All identified areas needing repair had a Work Order created by the Administrator to be addressed by maintenance by 5/20/16.	

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F 253	Continued From page 17 An inquiry about the status of the floors was made during the interview on 4/27/16 at 3:00 PM with the housekeeping (HK) supervisor. The housekeeping supervisor indicated he had a detailed cleaning schedule and protocol but never was able to produce or discuss the protocol. Interview on 4/28/16 at 2:35 PM with the Floor Technician (FT) revealed he was responsible for keeping the floors clean. An inquiry was made about the procedure for cleaning the floors and he indicated the supervisor scheduled the rooms to be cleaned and stripped of wax. The FT indicated he could not clean the floors while the residents were in there room but would not explain further. 2. a. Observation on 4/26/16 at 11 AM revealed the wall area behind the head of the bed in room #122B was torn in several areas. b. Observation on 4/26/16 at 2:37 PM revealed broken ceiling tile in room #234. There was a 10 inch by 10 inch hole in the bathroom wall of room #234. c. Observation on 4/26/16 at 3:16 PM revealed in room #120b there was peeling paint near the heating and air-conditioning unit. The veneer was missing off of the closet front. The bathroom door frame had multiple areas of chipped paint. d. Observations on 4/27/16 at 11:30 AM revealed the wall was crumbling behind the door in room #222. e. Observation on 4/27/16 at 11:22 AM revealed 4 separate areas of chipped paint on the wall and missing cove molding in room #204. f. Observation on 4/27/16 at 12:05 PM of the second floor dining room revealed peeling paint on the doorframe. g. Observation on 4/28/16 at 11:27 AM revealed in room #121 revealed the wall behind bed B was	F 253	During the audit a list was generated by the administrator of all identified cleaning concerns and given to the housekeeping manager to be addressed by housekeeping by 5/20/16. 3. Measures put in place or systemic changes made to ensure this deficient practice does not reoccur An inservice was completed with 100% of housekeeping staff to include housekeepers and floor technicians on the 5 and 7 step cleaning methods by the housekeeping supervisor by 5/20/16. All new housekeeping staff will be inserviced on the 5 and 7 step cleaning methods by the Housekeeping Supervisor during orientation. 100 % of the maintenance team, to include the maintenance director was inserviced on 5/17/16 by the Administrator regarding the need to conduct a daily walk-through of the facility to ensure that all of the facility□s maintenance needs are being met. Specifically, the in-service addressed the appropriate and proper use of the General Facility Daily Check List tool as well as the use and prioritization of work orders. All staff were inserviced by the Administrator on the completion of work orders to alert maintenance of areas/items in need of repair, to include but not limited to missing cove molding and tile, peeling paint, stains and build up on floors, windows and screens needing repair, and holes in walls, with the inservice completed by 5/20/16. All new hires will be inserviced on the completion	

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F 253	Continued From page 18 peeling. 3. a. Observation on 4/25/16 at 12:40 PM revealed a heavy accumulation of cobwebs outside of the window of Room #102. The screen to the window was partially detached from the window. Interview on 4/25/16 at 12:40 PM with an alert and oriented resident (who wanted to remain anonymous) revealed the cobwebs had been there for quite a while. b. Observation on 4/27/16 at 11:25 AM revealed in room #220 the window screen was partially detached from the window. There was an accumulation of debris between the window and screen. Multiple cobwebs were visibly noted approximately 12 inches across the window. c. Observations on 4/27/16 at 11:30 AM revealed cobwebs in the window of room #222. d. Observation on 4/27/16 at 11:50 AM revealed cobwebs between the partially detached window screen and window of room #224. e. Observation on 4/27/16 at 12 Noon revealed in room #228B the window screen was partially detached. There was an accumulation of multiple cob webs and tree branches between the partially detached screen and window. f. Observation on 4/27/16 at 12:05 PM of the second floor dining room revealed the dining room had 10 windows. One of the windows had a screen with holes. Eight (8) of the ten (10) windows had an accumulation of cobwebs. 4. a. Observation on 4/27/16 at 11:22 AM revealed in room #204 a missing plate over the electrical socket. b. Observation on 4/26/16 at 3:16 PM revealed in room #120b the face plate to the electrical socket was cracked.	F 253	of work orders to alert maintenance of areas/items in need of repair, to include but not limited to missing cove molding and tile, peeling paint, stains and build up on floors, windows and screens needing repair, and holes in walls, during the orientation process by the Administrator, DON, or Staff Facilitator. 4. How the facility plans to monitor the measures to make sure solutions are sustainable The Maintenance Manager or Maintenance Assistant will conduct a daily walk through of the facility including rooms # 102, 118 119, 120, 121, 122, 204, 220, 222, 224, 228, 230, 232, 234, 236, 237, 238, 239, 242, 2nd floor bath, elevator, and 2nd floor dining room Monday thru Friday using a General Facility Daily Check List Tool to ensure that the facility□s maintenance needs are being met. The Administrator will review sign and initial the General Facility Daily Check List (GFDCL) daily Monday thru Friday for a period of 4 weeks, then 2 x week x 4 weeks, then weekly x 8 weeks to insure that the maintenance needs of the facility are being met. The Housekeeping manager will conduct daily rounds Monday through Friday using a Quality Control Inspection (QCI) checklist auditing 2 rooms cleaned, to include deep cleaned rooms, per housekeeper to ensure compliance with cleaning procedures. The Administrator will review the QCI check list daily Monday thru Friday x 4 weeks, then 2 x week x 4 weeks, then weekly x 8 weeks to ensure	

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F 253	Continued From page 19 5. a. Observation on 4/25/16 at 9:40 AM revealed the wall radiator vent near the elevator had a partially detached end with sharp edges exposed. b. Observation on 4/26/16 at 1:34 PM revealed the bathroom sink shared by rooms #120-122 would not freely drain. Interview with the maintenance director on 4/28/16 at 2:45 PM indicated the building was old and when the staff sees items needed for repair a work order was completed. Further interview revealed all repairs are done by work orders. Review of the March 2016 and April 2016 facility work orders revealed no work orders for the above findings. Interview on 4/28/16 at 2:51 PM with the administrator and DM was held. The Administrator stated the facility had a working quality improvement program that focused on kitchen repairs, painting, waxing of floors, and replacing sheetrock. When inquired about the action plan, goals, dates/issues identified and completion times, the Administrator stated that she did not have established goal dates, goals or intervention. Further, interview with the Administrator revealed the facility always does detail cleaning every spring. The DM indicated the housekeeping staff performs deep cleaning of 2 rooms per week. The DM was not able to provide the rooms completed. Interview on 04/28/2016 at 5:59 PM with the Administrator who stated the expectation of her staff was to maintain a clean facility, follow policy and procedures and complete needed repairs.	F 253	that the housekeeping needs of the facility are being met. When a staff member identifies an item or area that needs repaired, they will complete a work order. The work order will be separated with a copy being placed in the Work Order Box found at each Nurse□s Station and the other copy placed in the Administrator□s mail box. The Administrator will check to ensure that the repairs have been made. An audit will be completed by the DON, ADON, and/or Staff Facilitator of 10 rooms/communal areas and 5 identified sample rooms/ communal areas, to include rooms # 102, 118 119, 120, 121, 122, 204, 220, 222, 224, 228, 230, 232, 234, 236, 237, 238, 239, 242, 2nd floor bath, elevator, and 2nd floor dining room, weekly x 16 weeks using the QI Housekeeping/ Maintenance Audit Tool. The results of the completed audits will be reviewed and initialed weekly x 16 weeks by the Maintenance Director, Housekeeping Supervisor and the Administrator. The Administrator will compile the results of the GFCDL checklist, QCI check list, and the QI Housekeeping/ Maintenance Audit Tool and present to the Executive QI Committee monthly x 4 months. The identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		5/23/16

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F 278	Continued From page 20 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 reviews, staff interviews, and observations, the facility failed to accurately assess 1 of 1 residents (Resident #86) for cognitive impairment and contractures. Findings included: Resident #86 was admitted to the facility on 11/16/12. A review of the quarterly minimum data set (MDS) dated 2/8/16 revealed Resident #86	F 278	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents.	

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(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 278	Continued From page 21 was not able to complete a brief interview for mental status (BIMS) and was severely cognitively impaired. There were no moods, behaviors, or rejection of care. Resident #86 was totally dependent on staff for all activities of daily living (ADLs), which included bed mobility and transfers, and had no upper or lower limb impairment. Active diagnoses coded on the MDS included: anemia, Alzheimer ' s disease, non-Alzheimer ' s dementia, Parkinson ' s disease, delirium, contractures of unspecified limbs and unspecified hand, and mild cognitive impairment. A review of the care plans dated 3/14/16 revealed care plans which included: requires assistance to maintain maximum function of self-sufficiency for mobility characterized by the following functions-positioning related to inability to move independently; alteration in supervised/organized recreation characterized by little or no involvement related to cognitive impairment; inability to express emotion and share information related to decline in cognitive status, urinary incontinence related to cognitive impairment; risk for falls characterized by history of falls/actual falls, multiple risk factors related to impaired cognition; and at risk for skin breakdown related to cognitive impairment. All care plans included measurable goals and interventions. An observation of Resident #86 on 4/27/16 at 10:00 AM, 12:00 PM, and 2:00 PM and additional observations on 4/28/16 at 9:00 AM and 11:00 AM revealed Resident #86 in bed with both lower extremities contracted with a pillows between both legs. An interview with Nurse #1 was conducted on 4/27/16 at 2:25 PM. She stated Resident #86 had bilateral lower limb contractures and was not able to get out of bed or reposition herself in the bed	F 278	The Plan of Correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F278 Assessment Accuracy/ Coordination/ Certified 1. Corrective Action for the resident affected The MDS assessment for resident #86 with an Assessment Reference Date of 2/18/2016 was modified on 4/27/16 by the MDS Nurse to correctly reflect the resident□s current condition to include coding for contractures and removal of diagnosis of mild cognitive impairment. 2. Corrective Action for residents having the potential to be affected An audit was completed 5/18/16 by the Staff Facilitator of the most recent MDS Assessment completed for 100% of residents, to include resident # 86, to ensure the assessments accurately reflect the resident□s current condition to include contractures (Section G) and diagnosis such as mild cognitive impairment	

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	345321	A. BUILDING _____ B. WING _____	04/28/2016

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F 278	Continued From page 22 without total staff assistance. An interview with Nurse #2 on 4/27/16 at 2:40 PM revealed she typically worked with Resident #86 and stated Resident #86 was totally dependent on staff for turning, repositioning, and transfers related to contractures of both lower and both upper extremities. An interview with Nursing Assistant (NA) #1 was conducted on 4/27/16 at 2:50 PM. She stated she was typically assigned to the hall Resident #86 resided on, and the resident was totally dependent on staff for all ADLs, which included bed mobility, turning, and transfers. An interview was conducted with the MDS nurse #1 on 4/27/16 at 3:15 PM. She stated MDS information was gathered from physician notes, hospital discharge summaries, nursing notes, lab reports, and face to face assessment. She stated contractures were areas that inhibited range of motion and included fractures, contractures, or paralysis, and were considered a limb impairment. She also stated Resident #86 was severely cognitively impaired, and should not have an active diagnosis of mild cognitive impairment. She also stated Resident #86 had contractures to both lower extremities and 1 hand and had limb impairments. She stated the MDS had not reflected an accurate assessment of Resident #86.	F 278	(Section I). For all areas of concern identified, a modification or Significant Correction of Prior Assessment (Quarterly/Comprehensive) was completed by the MDS Coordinator, Social Worker, Dietary Manager, and/or Activity Director as indicated by the RAI Manual on 5/18/16. 3. Measures put into place or systemic changes made to ensure the deficient practice does not reoccur Training was conducted for the Care Plan Team to include MDS Nurses, Social Worker, Dietary Manager, and Activity Director on 5/20/16 by the Facility MDS Consultant regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual to include coding for Section G and Section I. A teleconference on MDS completion was viewed by the Care Plan Team on 5/18/16. 4. How the facility plans to monitor the measures to make sure solutions are sustainable When coding the MDS assessment the MDS Nurse and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the resident□s current condition to include accuracy of coding Section G and Section I. The Staff Facilitator will review completed MDS assessments, to include Section G and Section I using the QI MDS	

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F 278	Continued From page 23	F 278	Accuracy Audit Tool, 10% of assessments to include assessment for resident #86 (if in progress during this time frame) will be reviewed weekly x 8 weeks, then 10 % of assessments will be reviewed monthly x 2 months. All identified areas of concern will be addressed immediately by the DON or ADON through retraining of care plan team staff and by modification or significant correction of the MDS assessment by the MDS Nurse to accurately reflect the resident□s current condition. The QI MDS Audit Tool will be reviewed and initialed by the Administrator or DON weekly x 8 weeks then monthly x 2 months to ensure compliance. Results of the QI MDS Accuracy Audit Tool will be compiled by the Administrator and presented to the Executive QI Committee monthly x 4 months. The identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
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:	F 323		5/23/16

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F 323	Continued From page 24 Based on record review, staff interviews, and observation, the facility failed to provide adequate supervision to 1 of 1 sampled residents (Resident #86) by leaving her unattended on an air mattress and this resulted in Resident #86 falling out of bed to the floor, and sustained a closed head injury (contusion with soft tissue swelling). Findings included: Resident #86 was admitted to the facility on 11/16/12 with cumulative diagnoses which included a history of falls, Parkinson ' s disease, and mild cognitive impairment. A review of the quarterly minimum Data Set (MDS) dated 11/17/15 and 2/8/16 revealed Resident #86 was totally dependent on staff for all activities of daily living (ADLs) except eating, was not able to complete the brief interview for mental status (BIMS) which indicated severe cognitive impairment, was not able to perform surface to surface transfers without staff assistance, had no upper or lower limb impairment, and had 1 fall since admission on 1/16/2016. Active diagnoses in the 11/17/15 and the 2/8/16 MDS included Parkinson ' s disease, contractures, and a history of falling. A review of the care plans dated 12/21/15 revealed Resident #86 required assistance to maintain maximum function of self-sufficiency for mobility characterized by positioning in bed related to (r/t) an inability to move independently. A review of the care guide for Resident #86 dated 1/18/16 included " Hi-low bed: return to lowest position after giving care. " A review of an incident report dated 1/18/16 revealed Resident #86 had an unwitnessed fall from the bed to the floor on 1/16/16 and was sent to the hospital r/t the fall. The incident report also revealed Resident #86 was confused and had decreased functional status, decreased safety	F 323	Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F323 Free of Accidents 1. Corrective action for the resident affected On 1/16/16 the air mattress was removed from the bed of Resident # 86 and replaced with a wing mattress. The resident□s care plan and care guide were updated on 1/18/16 to indicate proper positioning for resident when in bed as well as keeping bed in lowest position to prevent further falls. Education was provided to nursing staff, including NA # 2, NA #3 regarding proper positioning of resident in bed and placing bed in lowest position if indicated on resident care guide	

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F 323	Continued From page 25 awareness, and contractures. The incident report also included a statement from the nursing assistant (NA #2) who provided care to Resident #86 at the time of the fall. She stated she had left the resident ' s room to retrieved clean linens. When NA #2 returned to the room, Resident #86 was on the floor, positioned on her right side. A review of the emergency department discharge summary dated 1/16/2016 revealed Resident #86 sustained a " closed head injury with soft tissue swelling. " An interview was conducted on 4/27/16 at 4:25 PM with nursing assistant #2 (NA #2). She stated, " I had just changed her roommate (the roommate of Resident #86). When I went to check her I noticed she wasn't positioned properly in the bed. She had slid down so I tried to pull her up and into the middle of the bed as best as I could. She was on an air mattress. I pulled the covers back and noticed her pad was wet. I moved her to the middle of the bed as best as I could, put pillows on each side of her, she already had pillows by her head, and left the room to get linens. When I got back she was on the floor. The side rails were up when I left the room, I don't know how she fell out of the bed. I called for assistance and waited with her for EMS (Emergency Medical Services). The resident is not able move on her own, but she would slide down in the bed. She is a 2+ person assist (needed the assistance of 2 persons) for all ADLs including bed mobility, and there are care cards in the closets to tell us about the resident needs. We are also told of changes at change of shift. When I saw she wasn't positioned properly I guess I could've called for help to re-position her in the middle of the bed, but I didn ' t. " An observation was made on 4/28/16 at 9:03 AM of Resident #86 in bed with pillows propped under	F 323	and care plan prior to leaving the resident□s room by the DON on 4/28/16. 2. Corrective action for residents having the potential to be affected 100% of residents were assessed by the Patient Care Coordinator on 5/17/16, to include residents on air mattresses and resident # 86, to ensure residents were properly positioned in bed. Any issues identified were immediately addressed by the staff facilitator with reeducation of staff. An audit was conducted on 5/20/16 by the MDS Nurse to identify any special positioning needs for 100% of residents to include resident # 86. Residents□ Care Plans and Care Guides were updated to reflect any identified special positioning needs by MDS Nurse by 5/20/16. 100% observation was initiated for all CNAs by the staff facilitator, ADON, DON, and /or Supervisory Nurse with return demonstration to ensure they are positioning residents in bed, to include resident #86, in a safe manner to prevent falls. No CNA will be allowed to work without observation and return demonstration. Any issues identified will be immediately addressed by the staff facilitator, ADON, DON, and /or Supervisory Nurse with reeducation of staff. 3. Measures put in place or systemic changes made to ensure the deficient practice does not reoccur All CNAs to include NA #2, NA #3 were inserviced by the DON, ADON, and Staff Facilitator regarding the need to review a	

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F 323	Continued From page 26 her left side, the side rails were up, no staff were present in the room, and the bed was observed to be elevated above its lowest position. The nurse assigned to care for Resident #86 (Nurse #1) was observed as she entered the room at 9:08 AM and used the pendant control to lower the bed to its lowest position. Nurse #1 stated the bed was not in the lowest position when she entered the room, and could not state why. An interview was conducted with NA #3 on 4/28/16 at 9:10 AM. She stated she did not know who left the bed up and not in the lowest position. She stated it should be in the lowest position. She also stated Resident #86 was repositioned every 2 hours. She further stated Resident #86 was totally dependent on staff for bed mobility r/t not being able to move independently. An interview was conducted with Nurse #1 on 4/27/16 at 2:25 PM. She stated she typically cared for Resident #86 who was totally dependent on staff for all ADLs. She also stated Resident #86 was unable to move at all independently for at least the past 2 years r/t lower limb contractures. She also stated her bed was supposed to be in the lowest position when no staff were present. An interview was conducted with the facility administrator on 4/27/16 at 3:00 PM. She stated Resident #86 had a fall on 1/16/16. She stated, " As best as we can tell, she was lying on her back and her legs are contracted. Her knees fell to the side and she cannot control her movements and we think the momentum pulled her out of the bed. She is not able to turn and reposition herself in bed without staff assistance, and is totally dependent on staff for all her needs. She has no control of her body. She was on an air mattress when she fell, but we changed it to a winged mattress before she returned from the hospital.	F 323	resident□s care guide for special positioning needs prior to providing care, and of the need to provide the necessary supervision when caring for residents to prevent falls or injury to include proper positioning in bed and placing the bed in the lowest position if indicated on the resident care guide and resident care plan prior to leaving the resident unattended. Inservice to be completed by 5/20/16. All CNAs will not be allowed to work until inserviced. All newly hired CNAs will be inserviced during the orientation process by the DON, ADON or Staff Facilitator regarding the need to review a resident□s care guide for special positioning needs prior to providing care, and of the need to provide the necessary supervision when caring for residents to prevent falls or injury to include proper positioning in bed and placing the bed in the lowest position if indicated on the resident care plan and care guide prior to leaving the resident unattended. 4. How the facility plans to monitor the measures to make sure solutions are sustainable. Prior to providing care for a resident, the CNA will review the Resident Care Guide to determine if the resident has any special positioning needs. During care the CNA will ensure that the resident is provided with the appropriate level of supervision and is positioned properly in bed and bed is placed in the lowest position if indicated on the resident care guide prior to leaving the resident unattended to prevent falls or injury. Special positioning needs for residents will	

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F 323	Continued From page 27 We also in-serviced all the staff on how to properly position Resident #86, and updated her care plan. We tried a high winged mattress, but her family member refused it, so we put a medium sized winged mattress and the family was agreeable to that. " An interview was conducted with the Director of Nursing (DON) on 4/27/16 at 3:55 PM. She stated, "When she's (Resident #86) lying flat on her back her knees are hyper-flexed and her head is up. She will start to roll to one side or the other. So we figured she started to roll and got some momentum going. If she just fell she would've landed on her back or left side. But she was on her right side so she had to have rolled. She didn't move herself intentionally. It's a center of gravity thing. We have her in a winged mattress now. She had not fallen out of bed before. She went to the emergency department and had a hematoma on her head. " The DON also stated Resident #86 was on an air mattress at the time of the fall, was a falls risk since she was admitted, but not as of March 2014 r/t not being able to move independently. She stated resident #86 was not able to move in bed, or reposition herself without staff assistance since March 2014. She also stated Resident #86 was not able to climb over the side rails.	F 323	be reviewed quarterly by the MDS staff during care plan review and when a change in condition occurs as identified during review of 24 hour reports by administrative nursing staff during morning meeting with updating of resident care plan and resident care guide as indicated. Resident care audits, to include resident # 86, will be conducted by the DON, ADON, Staff Facilitator, and Patient Care Coordinator using the QI Positioning/ Supervision of Residents Audit Tool to ensure that CNAs are positioning the resident properly in bed and placing bed in the lowest position if indicated on the resident care guide and resident care plan prior to leaving resident unattended to prevent falls or injury for 10 % of CNAs 5 x a week to include nights and weekends x 4 weeks, then 10 % of the CNAs weekly to include nights and weekends x 8 weeks, then 10 % of the CNAs monthly to include nights and weekends x 1 month. Any identified concerns will be addressed immediately by the DON, ADON, Staff Facilitator, and Patient Care Coordinator with reeducation of CNAs. The DON or Administrator will review and initial the QI Positioning/ Supervision of Residents Audit Tool weekly x 12 weeks then monthly x 1 month. The Administrator will compile the results of the QI Falls Positioning/ Supervision of Residents Audit and present the findings to the Executive QI Committee monthly x 4 months. The identification of trends will determine the need for further action and/or change in frequency of required	

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F 323	Continued From page 28	F 323	monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		5/23/16

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This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to follow infection control procedures by not putting on gloves when entering a room with signage for Contact Precautions and by not putting on a gown when administering medications via gastrostomy tube for one of one residents (Resident # 86) on Contact Precautions.

The findings included:

A review of Resident #86 ' s medical record revealed the resident was diagnosed with Clostridium difficile (a spore-forming bacteria) and began a 14-day course of antibiotic treatment on 4/16/16.

A review of the Center for Disease Control ' s (CDC) recommended infection control practices in long term care settings for patients with known or suspected Clostridium difficile infection included the implementation of Contact Precautions. The recommendations specifically indicated gloves and gowns should be used when entering patients ' rooms and during patient care.

A review was conducted of the facility ' s Infection Control Manual which included a section titled, " Contact Precautions " dated September 2014. This section read, in part:
" Contact precaution recommendations include:
--Utilize clean gloves when entering resident's room and during care...
--Wear a gown when entering room and caring

Kerr Lake Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Kerr Lake Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Kerr Lake Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.
F441 Infection Control

1. Corrective action for the resident affected
Immediate re-education of Nurse # 2 was provided by the DON on 4/27/16 regarding the infection control protocol for use of Personal Protective Equipment (PPE) when caring for residents on Contact Precautions.

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F 441	Continued From page 30 for the resident..." On 4/27/16 at 4:20 PM, a Contact Precaution sign was observed to be posted on the door going into Resident #86 ' s room. The Contact Precautions sign read in part: "--Perform hand hygiene before entering and before leaving room --Wear gloves when entering room or cubicle, and when touching patient's intact skin, surface, or articles in close proximity. --Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces..." Personal Protective Equipment (PPE), including gloves and gowns, were observed to be hung on the outside of the door to the resident ' s room. On 4/27/16 at 4:20 PM, Nurse #2 was observed at her medication cart as she prepared four medications and water flushes to be administered to Resident #86 via gastrostomy tube. At 4:22 PM, the nurse entered Resident #86's room without putting on either gloves or a gown. The nurse touched the resident's shoulder to awaken her, and rolled the resident ' s bedside tray table from the bedside to the doorway at the entrance to the room. Nurse #2 was observed as she reentered the room, went into the resident's bathroom and washed her hands. The nurse then closed the bathroom door using the door knob and went to the medication cart located outside the room. At 4:27 PM, Nurse #2 performed hand hygiene at the medication cart using hand sanitizer. At 4:30 PM, the nurse re-entered Resident #86 ' s room to set a water jug and medication supplies on the bedside tray table near the doorway. She did not have on	F 441	2. Corrective action for residents having the potential to be affected 100% audit of staff to include Nurse # 2 was initiated on 5/19/16 by the MDS Nurse, ADON, treatment nurse, and patient care coordinator of observation with return demonstration of proper donning and doffing of personal protective equipment (PPE), and hand-washing to ensure correct isolation precautions/isolation protocols are followed. Any identified areas of concerns were immediately addressed by the MDS Nurse, ADON, treatment nurse, and patient care coordinator during the audit. No staff member will work until observed and checked off on donning and doffing of PPE by the MDS Nurse, ADON, treatment nurse, and patient care coordinator. 3. Measures put in place or systemic changes made to ensure this deficient practice does not reoccur 100% of staff to include Nurse # 2 were re-educated by the Staff Facilitator, DON, ADON, and MDS Nurses on precautions/isolation protocols, including Contact Precautions, Education included donning gloves and gown prior to entering resident□s room, to include when administering medications via gastrostomy tube, washing hands after removing personal protective equipment and prior to entering another resident□s room. Inservice completed by 5/20/16. All newly hired staff will be inserviced on donning gloves and gown prior to entering resident□s room, to include when	

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	345321	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR LAKE NURSING AND REHABILITATION CENTER	1245 PARK AVENUE HENDERSON, NC 27536

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F 441	Continued From page 31 gloves or a gown. The nurse again went into the bathroom inside Resident #86 ' s room and washed her hands, then brought a paper towel from the bathroom and laid it on the bedside table placed at the entrance to the room. At 4:33 PM, she moved the bedside table from the doorway and positioned it next to Resident #86's bed. The nurse put on gloves at that time; she did not put on a gown. At 4:38 PM, Nurse #2 was observed as she moved the resident's bed sheet and gown, disconnected her tube feeding, attached a syringe to the tube, and flushed the tube with water. After flushing the tube, a small amount of fluid was noted to splash from the stomach contents up into the open-ended syringe attached to the tubing. Each of the four medications were administered with water flushes and the feeding tube was reconnected. The nurse pulled the trash bag from the trashcan and removed her gloves, placed them in the trash bag, sealed the bag, placed the trash bag in the resident ' s bathroom. She washed her hands before exiting the room. An interview was conducted with Nurse #2 on 4/27/16 at 4:45 PM. During the interview, inquiry was made regarding the resident's Contact Precautions. Upon inquiry, the nurse reported Resident #86 was on Contact Precautions for Clostridium difficile. When asked, Nurse #2 stated she only needed to don a gown, "when we do incontinence care." On 4/28/16 at 9:50 AM, an interview was conducted with the Director of Nursing (DON) regarding infection control and contact precautions. The DON reported she herself assumed responsibility for the facility ' s Infection Control program. The DON confirmed Resident	F 441	administering medications via gastrostomy tube washing hands after removing personal protective equipment and prior to entering another resident□s room by the Staff Facilitator during orientation. 4. How the facility plans to monitor the measures to make sure solutions are sustainable. When a resident is placed on transmission based precautions, the infection control nurse, DON, or ADON will ensure that the appropriate transmissions based precaution sign, to include Contact Precautions, is placed on the resident□s door indicating the PPE requirements and proper infection control practices indicated for the individual resident. Resident care audits will be conducted by the DON, ADON, Staff Facilitator, or Patient Care Coordinator, to observe staff, to include Nurse # 2, caring for residents on transmission based precautions, to include resident # 86 and those residents on Contact Precautions, 10% of staff 5 x a week, to include nights and weekends, x 4 weeks, then 10% of staff 3 x a week, to include nights and weekends, x 4 weeks, then 10% of staff 1 time a week to include nights and weekends, x 2 months using a QI Infection Control Audit Tool to ensure staff are using the appropriate PPE and using proper infection control techniques when caring for residents on transmission based precautions. The QI Infection Control Audit tools will be reviewed and initialed weekly by the Administrator or	

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F 441	Continued From page 32 #86 was currently on Contact Precautions for Clostridium difficile. The DON reported a gown only needed to be donned only if the staff member was expected to come into contact with infectious material. The DON indicated she did not think the nurse needed to put on a gown when administering medications via gastrostomy tube to Resident #86 on Contact Precautions. However, she did acknowledge gloves needed to be put on whenever someone entered a Contact Precautions room to provide care for the resident.	F 441	DON to ensure compliance.	