STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY GLEN	849 WATER WORKS ROAD WINSTON-SALEM, NC 27105

(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 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 code the Minimum Data Set (MDS) assessments accurately for 4 (Residents # 13, #111, #59 & # 28) of 17 sampled residents in the areas of falls, dialysis and medication. Findings included:	F 278	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is	9/8/16

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

Electronically Signed | 08/26/2016

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F 278	Continued From page 1 1. Resident #13 was readmitted to the facility on 6/11/15. The significant change in status MDS assessment dated 6/1/16 was reviewed. The assessment indicated that Resident #13 had severe cognitive impairment and had 1 fall with no injury since admission, reentry or prior assessment (3/15/16). The incident reports were reviewed. The reports indicated that Resident #13 had falls on 3/20/16 with no injury, on 4/17/16 with injury and on 4/28/16 with no injury. On 8/10/16 at 12:10 PM, MDS Nurse #1 was interviewed. MDS Nurse #1 stated that MDS Nurse #2 completed the significant change in status assessment for Resident #13. She added that MDS Nurse #2 started as MDS Nurse in January 2016. MDS Nurse #2 was new to MDS, had not received MDS training yet, and she was still learning. MDS Nurse #1 acknowledged that the assessment should have been coded 2 for falls without injury and 1 for falls with injury. 2. Resident #111 was readmitted to the facility on 7/2/16. The significant change in status MDS assessment dated 7/9/16 indicated that Resident #111 did not receive dialysis while at the facility. The electronic records for Resident #111 were reviewed. The records indicated that on 7/7/16 at 11:24 AM, Resident #111 had left for dialysis via facility transportation and was back at 4:34 PM. The records dated 7/9/16 indicated that Resident #111 had left for dialysis at 11:00 AM via family car and was back at 5 PM.	F 278	prepared solely because it is required by the provision of federal and state law. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date(s) indicated. F278 (D) Assessment Accuracy/Coordination/Certified Trinity Glen will continue to complete assessments that accurately reflect the resident's status. For all residents affected: Minimum Data Set (MDS) assessments were modified and transmitted by the MDS Nurse #1 for residents as follows: resident #13 (to reflect 2 falls no injury, 1 fall with injury) 8-10-16, #111 (to include dialysis)8-10-16, #59 (to include multiple falls with no injury and 1 fall with injury)8-10-16 & #28 (to include no hypnotic on quarterly 8-12-16 and no hypnotic on annual 8-24-16). For all residents that have the potential to be affected: Current assessments were reviewed by Registered Nurse (RN) consultant on 8-23-16 for other residents coded with falls, dialysis and hypnotic medications. No errors were noted on area of dialysis. 4 Corrections were needed in the area of falls. 9 corrections were needed in the area of hypnotic medications. Any errors identified were corrected through	

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F 278	Continued From page 2 On 8/10/16 at 2:15 PM, MDS Nurse #1 was interviewed. MDS Nurse #1 stated that MDS Nurse #2 completed the significant change in status assessment for Resident #111. She added that MDS Nurse #2 started as MDS Nurse in January 2016. MDS Nurse #2 was new to MDS, had not received MDS training yet, and she was still learning. MDS Nurse #1 acknowledged that the assessment was coded incorrectly, Resident #111 had received dialysis while at the facility. 3. Resident #59 was admitted to the facility on 6/1/16 with multiple diagnoses that included right knee effusion. The admission Minimum Data Set (MDS) assessment dated 6/8/16 indicated she had moderate cognitive impairment. Section J, the Health Conditions Section, indicated Resident #59 had two or more falls without injury and zero falls with injury (minor or major) since her admission to the facility. A review of the medical record indicated Resident #59 had five total falls since her admission through the MDS review period (6/1/16 through 6/8/16). These five falls included four falls without injury (6/3/16, 6/6/16, 6/7/16, and 6/8/16) and one fall with injury (6/6/16). The injury documented for the fall on 6/6/16 indicated Resident #59 had a hematoma on her left forehead and she complained of pain in her left upper extremity, left lower extremity, and her head. An interview was conducted with MDS Nurse #1 on 8/10/16 at 12:08 PM. The MDS dated 6/8/16 for Resident #59 was reviewed with MDS Nurse #1. The medical record documentation of falls from 6/1/16 through 6/8/16 for Resident #59 was reviewed with MDS Nurse #1. She revealed this was an error and had just had been missed. She	F 278	modifications and transmitted by MDS nurse #1 on 8-24-16. Measures put in place to ensure deficient practice will not reoccur: MDS nurses #1 & 2 will be re-educated by 8-31-16 by the Corporate Nurse Consultant on accurate coding for MDS assessments including falls, dialysis and medications. An RN auditor (a registered Nurse that has MDS experience but does not have primary duty of MDS in this facility) will check any MDS' completed for residents with falls, dialysis, or hypnotic medications weekly for one quarter, then monthly for one year to verify that MDS has been coded properly. An audit tool will be used that lists: resident name; audit date; assessment date; MDS items listed in sections J (falls with or without injury or major injury), O (Dialysis), and N (antianxiety and hypnotic medications). Completed MDS will be verified by checking chart for resident in the areas of falls, dialysis and Medications; utilizing physician orders, MAR, nurses notes and incidents. Any modifications required will be made and transmitted at that time by MDS nurse. Monitoring plan to ensure solutions are sustained: Director of Nursing (DON)/Assistant DON will audit 5 completed MDS' monthly to ensure coding has been completed accurately and report to Quality Assurance Performance Improvement (QAPI) - (MDS Performance Improvement Plan (PIP) team). The MDS PIP team	

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F 278	Continued From page 3 reported a revision was going to be submitted. MDS Nurse #1 indicated she and MDS Nurse #2 were both completing MDS assessments and she was not certain who had completed Section J of this MDS (6/8/16) for Resident #59. MDS Nurse #1 explained that MDS Nurse #2 began working in her position in January of 2016 and was new to the MDS process. She indicated MDS Nurse #2 had not completed formal training of the MDS. MDS Nurse #1 indicated that MDS Nurse #2's assessments were being reviewed for accuracy. She stated that the MDS was an easy place to make a mistake and this was an error that had been missed. An interview was conducted with the Director of Nursing on 8/11/16 at 10:33 AM. She indicated she expected the MDS to be coded accurately. 4. a. Resident #28 was admitted to the facility 6/10/11. Cumulative diagnoses included: Alzheimer's disease, diabetes, insomnia, dementia without behavioral disturbance, psychosis, depression and anxiety. A review of physician orders for August 2016 revealed the following medications: Ativan (anti-anxiety medication) 0.5 milligrams by mouth daily, Remeron (antidepressant medication) 15 milligrams by mouth daily, Zyprexa (antipsychotic medication) 2.5 milligrams by mouth daily and Lantus insulin 50 units subcutaneous daily at bedtime. An Annual Minimum Data Set (MDS) dated 2/3/16 indicated Resident #28 had short term and long term memory impairment and was severely impaired in decision-making. No behaviors were noted. Medications administered during the assessment period was noted as follows: seven	F 278	includes MDS Nurse #1, MDS Nurse #2, DON, and Administrator. The team will identify any trends and change the plan as needed. MDS nurses will report the data collected and any changes made to the plan in the quarterly QAPI meeting for one year.	

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F 278	Continued From page 4	F 278		

days of injection, seven days of insulin administration, seven days of antipsychotics, seven days of antidepressants, seven days of antianxiety medication and seven days of hypnotic medication.

A review of the Medication Administration Record (MAR) for the look back period of 1/28/16 --2/3/16 revealed the following medications were administered-Lantus insulin, Ativan, Zyprexa, Remeron. There was no hypnotic medication noted as having been administered during that time frame.

On 8/11/2016 at 7:54AM, an interview was held with both MDS coordinators. They stated they coded the Ativan as an antianxiety and as a hypnotic because it was noted in the drug book as being a hypnotic as well as an antianxiety medication. They reviewed the manual used to complete the MDS and noted that medications should be coded according to their classification.

On 8/11/16 at 10:33AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.

b. Resident #28 was admitted to the facility 6/10/11. Cumulative diagnoses included: Alzheimer's disease, diabetes, insomnia, dementia without behavioral disturbance, psychosis, depression and anxiety.

A review of physician orders for August 2016 revealed the following medications: Ativan (anti-anxiety medication) 0.5 milligrams by mouth daily, Remeron (antidepressant medication) 15 milligrams by mouth daily, Zyprexa (antipsychotic medication) 2.5 milligrams by mouth daily and

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F 278	Continued From page 5 Lantus insulin 50 units subcutaneous daily at bedtime. A Quarterly MDS dated 7/22/16 indicated Resident #28 had short term and long term memory impairment and was severely impaired in decision-making. No behaviors were noted. Medications administered during the assessment period was noted as follows: seven days of injection, seven days of insulin administration, seven days of antipsychotics, seven days of antidepressants, seven days of antianxiety medication and seven days of hypnotic medication. A review of the Medication Administration Record (MAR) for the look back period of 7/16/16--7/22/16 revealed the following medications were administered-Lantus insulin, Ativan, Zyprexa, Remeron. There was no hypnotic medication noted as having been administered during that time frame. On 8/11/2016 at 7:54AM, an interview was held with both MDS coordinators. They stated they coded the Ativan as an antianxiety and as a hypnotic because it was noted in the drug book as being a hypnotic as well as an antianxiety medication. They reviewed the manual used to complete the MDS and noted that medications should be coded according to their classification. On 8/11/16 at 10:33AM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be accurate.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		9/8/16

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F 282	Continued From page 6 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to follow the plans of care for range of motion (Residents #40, #4, and #107) and accidents (Residents #13 & #151) for 5 of 17 sampled residents. Findings included: 1. Resident #40 was admitted to the facility on 3/31/14 with multiple diagnoses that included osteoporosis, diabetes mellitus, and intellectual disabilities. The quarterly Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #40 had moderate cognitive impairment and a limited range of motion to both sides of her lower extremities. A review of Resident #40's plan of care, with a review date of 7/12/16, revealed interventions to address the range of motion (ROM) and functioning of her bilateral upper extremities (BUE) and the prevention of further contractures to her bilateral lower extremities (BLE). The interventions indicated restorative services were to apply a knee separator daily to Resident #40 for 4-6 hours per day in the morning and a resting right hand splint 6 days per week. Additionally, passive range of motion (PROM) was to be provided to Resident #40 on 6 days per week for her BLE and BUE.	F 282	F282 (D) Services by Qualified Persons/Per Care Plan Trinity Glen will continue to provide services by qualified persons in accordance with each resident's written plan of care. For all residents affected: Resident #13 had pommel cushion and chair alarm put into place on 8-10-16. Resident #151 had chair alarm put into place on 8-10-16. Residents #13 & 151 were reviewed by the interdisciplinary team (IDT included: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing) to assess the plan of care for accidents on 8-11-16. Resident #13 & 151 were discussed by team for toileting program. Bedside commode was placed in room of Resident #13 by Therapy on 8-11-16. Resident #13 sent to ED & expired on 8-13-16. Staff Development to educate staff on toileting plan for Resident #151 on 8-25-16 and then implement. Residents #40, 4, & 107 were re-evaluated by therapy to ensure treatment plans for splints/Range of Motion (ROM) were still appropriate on 8-24-16. Residents #40, 4, & 107 were reviewed by the interdisciplinary team	

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F 282	Continued From page 7 A review of Resident #40's restorative services documentation from 7/13/16 through 8/10/16 revealed restorative services were provided on 12 out of 29 calendar days. There were 17 days during the review period of 7/13/16 through 8/10/16 that Resident #40 was not provided restorative services. The 17 days that restorative services were not provided were: 7/16-7/18, 7/21, 7/23-7/31, 8/3-8/5, and 8/7. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00 PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #40 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #40 had not received restorative as indicated on her plan of care for 17 out of 29 days. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #40 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could not explain why Resident #40 had not received restorative services as indicated on her plan of care for 17 out of 29 days. An interview was conducted with Restorative Nursing Assistant (RNA) #1 on 8/11/16 at 9:45 AM. She indicated she normally worked with Resident #40. She indicated she reviewed the documentation from the time period in question (7/13/16 - 8/10/16) for Resident #40. RNA #1 revealed that if restorative services were not	F 282	including therapy to assess the plan of care for splints/range of motion on 8-24-16, plans were continued. For all residents that have the potential to be affected: All residents with orders for splints/ROM were reviewed on 8-24-16 by the interdisciplinary team (IDT) (IDT included: Therapy manager, ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator) to assess the continued plan of care. One splint/ROM order was added and one device order was discontinued as not an actual splint. All residents with a plan of care for accidents were reviewed on 8-25-16 by the interdisciplinary team (IDT included: ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator, and Supervisor) to assess the continued plan of care. Team made 14 changes to care plans and 38 order clarifications. Changes were made to the plans of care for the most appropriate course of action and orders were adjusted to reflect changes on 8-25-16. Restorative Nursing Assistants (RNA) #1 & 2 were re-educated by Restorative Nursing Assistant (RNA) Supervisor on 8-11-16 and counselled by Director of Nursing (DON) on 8-26-16 regarding the omissions and the importance of range of motion and splinting. Four new Restorative Nursing Assistants will be trained by Staff Development Coordinator (SDC) by 8-31-16 and will be utilized to ensure services are provided as ordered. Nurses, Medication Administration Aides	

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documented that they had not occurred. She indicated if she had provided the restorative services to Resident #40 she would have completed the documentation. She stated she "just missed those days". RNA #1 stated she received a computer generated list each morning of all residents she was assigned to provide restorative services. She indicated she had a large volume of residents on her caseload and sometimes she was not able to get to all of her residents. RNA #1 stated she had not been reporting to her supervisor, MDS Nurse #2, if she was unable to provide restorative services as indicated on her assignment sheet.

A follow up interview was conducted with MDS Nurse #2, the supervisor restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services in March 2016. She indicated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments.

A follow up interview was conducted with the DON on 8/11/16 at 10:30 AM. She indicated she expected restorative services to be provided as indicated in the plan of care. She stated she expected RNAs to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she

(MAA)s and Nursing Assistant(NA)s (including NA #1 & 3) will be re-educated by Staff Development Coordinator (SDC)/Supervisor/ Director of Nursing (DON) by 9-7-16 to check kiosk for supportive devices on plan of care.

Measures put in place to ensure deficient practice will not reoccur:
System developed to have Assistant DON/Staff Development Coordinator (SDC)/RNA Supervisor audit restorative documentation at least 3 times per week and meet with RNAs to discuss any omissions or issues. Reports will be given to RNA supervisor for any omissions or issues and changes will be made to plans of care/orders as needed. Caseload of RNA will be reviewed by DON/RNA Supervisor on an ongoing basis to ensure appropriateness of continued need for resident programs. A list of splints and alarms will be reviewed in weekly Trek meeting (a meeting to discuss: falls, weights, skin issues or any other incidents that is attended by (IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing). Any revisions will be given to the hall nurse/Supervisor by ADON each week for review in huddle meetings (a meeting for hall staff to discuss each resident's care or issues) with nurse, MAA, nursing assistants. Monitoring will be done by Charge Nurse/Supervisor/MDS Nurse on each hall 3 times per week for one year to ensure splints/supportive devices are in

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F 282	Continued From page 9 had not known restorative services were not provided consistently. 2. Resident #4 was admitted to the facility on 10/12/12 with multiple diagnoses that included cerebral palsy. The significant change Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #4 had significant cognitive impairment and a limited range of motion to one side of his upper extremities and both sides of his lower extremities. A review of Resident #4's plan of care, with a review date of 8/3/16, revealed interventions to address the prevention of further contractures to his bilateral lower extremities (BLE) and to maintain his current functional bed mobility. The interventions indicated restorative services were to provide a splint to Resident #4's bilateral knees 1 to 3 hours daily and assist with passive range of motion (PROM) to lower extremities and bed mobility exercises 6 days per week. A review of Resident #4's restorative services documentation from 8/4/16 through 8/10/16 revealed restorative services were provided on 3 out of 7 calendar days. There were 4 days during the review period of 8/4/16 through 8/10/16 that Resident #4 was not provided restorative services. The 4 days that restorative services were not provided were: 8/4 and 8/6-8/8. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00 PM. She indicated she was the supervisor of restorative services. The restorative services documentation for Resident #4 was reviewed with MDS Nurse #2. She	F 282	place as ordered/care planned for 10% or more of residents. This will be documented on a Splint/Supportive Devices Audit Tool, which includes Resident, device, in place – Y or N, if no what action was taken. Monitoring plan to ensure solutions are sustained: RNA Supervisor will report results of weekly audits on omissions quarterly to Quality Assurance Performance Improvement (QAPI) for one year as well as any changes made to the plan regarding documentation of splints/range of motion and accidents.	

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revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days.

An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #4 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days.

An interview was conducted with Restorative Nursing Assistant (RNA) #2 on 8/11/16 at 9:45 AM. He indicated he normally worked with Resident #4. He indicated he reviewed the documentation from the time period in question (8/4/16 - 8/10/16) for Resident #4. RNA #2 stated that if restorative services were not documented that they had not occurred. He indicated if he had provided the restorative services to Resident #4 he would have completed the documentation. He stated he received a computer generated list each morning of all residents he was assigned to provide restorative services. RNA #2 indicated he had a large volume of residents on his caseload and on occasion he was pulled away from restorative services to assist the nurse on the floor. He stated that when he was pulled to the floor it was difficult to get back on track with his restorative services and to complete all of his assignments. RNA #2 stated he had not been reporting to his supervisor, MDS Nurse #2, if he was unable to provide restorative services as

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indicated on his assignment sheet.

A follow up interview was conducted with MDS Nurse #2, the supervisor restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services in March 2016. She indicated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments.

A follow up interview was conducted with the DON on 8/11/16 at 10:30 AM. She indicated she expected restorative services to be provided as indicated in the plan of care. She stated she expected RNAs to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she had not known restorative services were not provided consistently.

3. Resident #13 was readmitted to the facility on 6/11/15. The significant change in status MDS assessment dated 6/1/16 indicated that Resident #13 had severe cognitive impairment and had a fall with no injury.

The care plan dated 7/3/16 was reviewed. One of the care plan problems was " I have a fall " and the goal was " I will have no injury due to falls. " The approaches included chair alarm and

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F 282	Continued From page 12 pommel cushion in wheelchair. On 8/9/16 at 9:50 AM and on 8/10/16 at 11:30 AM, Resident #13 was observed up in wheelchair. Resident #13 was observed with no chair alarm nor pommel cushion in his wheelchair. On 8/10/16 at 11:30 AM, NA #2 was interviewed. NA #2 was assigned to Resident #13. She stated that Resident #13 was a high risk for falls and has a chair alarm in his wheelchair to alert the staff that he was trying to get up. NA #2 added that the night shift staff got him up this morning and didn't know why he didn't have the chair alarm in his wheelchair. NA #2 also indicated that Resident #13 was not using a pommel cushion in his wheelchair. On 8/10/16 at 11:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the care plan to prevent further falls. The DON added that Resident #13 should have the chair alarm and pommel cushion in his wheelchair as care planned. 4. Resident #151 was admitted to the facility on 8/8/15. The annual MDS assessment dated 8/5/16 indicated that Resident #111 had severe cognitive impairment and had a fall with injury. The care plan dated 8/8/16 was reviewed. One of the care plan problems was " I have falls related to history of falls " and the goal was " I will not have any injury related to falls. " The approaches included a chair alarm.	F 282		

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On 8/10/16 at 10:45 AM, Resident #151 was observed up in wheelchair in her room. She did not have a chair alarm in her wheelchair.

On 8/10/16 at 10:46 AM, NA #3 was interviewed. NA #3 was assigned to Resident #151. She stated that the resident was a high risk for falls and has a chair alarm to alert the staff that she was getting out of her chair. NA #3 added that she was off for 2 days and didn't know why the resident did not have the chair alarm in her wheelchair.

On 8/10/16 at 11:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the care plan to prevent further falls. She added that Resident #151 should have a chair alarm when up in wheelchair.

5. Resident #107 was originally admitted to the facility 3/13/15. Cumulative diagnoses included dementia, hypertension, diabetes, dysphagia (difficulty swallowing), aphasia (absence of speech) and gastrostomy tube (feeding tube in the stomach).

A Significant Change Minimum Data Set (MDS) dated 6/14/16 indicated Resident #107 had short term and long term memory impairment and severely impaired in decision-making skills. Total care was required for all activities of daily living (ADL). Range of motion noted impairment on both sides for upper and lower extremities.

A care plan dated 8/4/16 indicated Resident #107 needed nursing ADL rehabilitation for her right upper extremity (RUE) related to possible

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contractures. Approaches included restorative nursing was to provide passive range of motion to RUE daily and apply splint to RUE daily for 3-4 hours. Use a calm, gently approach and monitor for skin breakdown.

On 8/10/16 at 8:05AM, an observation of Resident #107 revealed Resident #107 with a right elbow splint in place and a hand splint on her right hand.

On 8/10/16 at 10:51 AM, an interview was conducted with NA#1. She stated restorative nursing had just started applying braces to Resident #107's right elbow and hand last week. She stated the splints were applied by restorative staff, kept on for a couple of hours or so and removed by restorative nursing staff.

A review of restorative nursing notes noted splint/ brace applied to Resident #107's right elbow and hand on 8/4/16, 8/5/16, 8/8/16, 8/9/16 and 8/10/16. There was no documentation that the brace and splint had been applied to Resident #107 on 8/6/16 or 8/7/16.

An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #107 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #107 had not received restorative as indicated on her care plan for 8/6/16 or 8/7/16.

An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7

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days a week. She stated she reviewed the staff schedules for the dates restorative services were not provided for Resident #107 and confirmed a restorative aide was working on both days. She revealed she could not explain why Resident #107 had not received restorative services as indicated on her care plan.

On 8/11/16 at 9:47 AM, an interview was conducted with Restorative Nursing Assistant #2. He stated he was responsible for the application of the brace and splint application for Resident #107 on 8/6/16 and 8/7/16. He stated restorative staff often got pulled to do other duties and it was hard to keep "on track" with restorative duties when that happened. Restorative Nursing Assistant #2 stated he was told to do other duties on 8/6/16 and 8/7/16 along with doing restorative nursing so he could not get to everybody. He stated if the brace and splint had been applied on 8/6/16 and 8/7/16, it would have been documented.

A follow up interview was conducted with MDS Nurse #2, the supervisor of restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services on March 2016. She stated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments.

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F 282	Continued From page 16 On 8/11/2016 at 10:28 AM, an interview was conducted with the Director of Nursing. She stated she expected the care plan to be followed.	F 282		
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 observation, medical record review, and staff interview, the facility failed to consistently provide range of motion and splinting for 3 of 3 residents (Residents #40, #4, and #107) reviewed for a limited range of motion. 1. Resident #40 was admitted to the facility on 3/31/14 with multiple diagnoses that included osteoporosis, diabetes mellitus, and intellectual disabilities. The quarterly Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #40 had moderate cognitive impairment and a limited range of motion to both sides of her lower extremities. A review of Resident #40's plan of care, with a review date of 7/12/16, revealed interventions to address the range of motion (ROM) and	F 318	F318 (D) Increase/Prevent Decrease in Range Of Motion Trinity Glen will continue to do comprehensive assessments of residents and ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. For all residents affected: Residents # 40, 4, and 107 were re-evaluated by therapy to ensure treatment plans for splints/Range of Motion (ROM) were still appropriate on 8-24-16. Residents # 40, 4, and 107 were reviewed by the interdisciplinary (IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing) to	9/8/16

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F 318	Continued From page 17 functioning of her bilateral upper extremities (BUE) and the prevention of further contractures to her bilateral lower extremities (BLE). The interventions indicated restorative services were to apply a knee separator daily to Resident #40 for 4-6 hours per day in the morning and a resting right hand splint 6 days per week. Additionally, passive range of motion (PROM) was to be provided to Resident #40 on 6 days per week for her BLE and BUE. A review of Resident #40's restorative services documentation from 7/13/16 through 8/10/16 revealed restorative services were provided on 12 out of 29 calendar days. There were 17 days during the review period of 7/13/16 through 8/10/16 that Resident #40 was not provided restorative services. The 17 days that restorative services were not provided were: 7/16-7/18, 7/21, 7/23-7/31, 8/3-8/5, and 8/7. An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00 PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #40 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #40 had not received restorative as indicated on her plan of care for 17 out of 29 days. An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #40 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could	F 318	assess the continued plan of care for splints/range of motion on 8-11-16, plans were continued. For all residents that have the potential to be affected: All residents that have been coded on Minimum Data Set (MDS) as limited range of motion have been reviewed by the interdisciplinary team (IDT) (IDT included: Therapy manager, ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator) on 8-24-16 to assess the continued plan of care for splints/range of motion, including duration of splint application. One splint/ROM order was added and one device order was discontinued as not an actual splint. Any changes were made to the plan of care and orders were updated as needed on 8-24-16. Restorative Nursing Assistants (RNA) #1 & 2 were re-educated by RNA Supervisor on 8-11-16 and counselled by DON on 8-26-16 regarding the omissions and the importance of range of motion and splinting. Four new Restorative Nursing Assistants will be trained by 8-31-16 and will be utilized to ensure services are provided as ordered. Nurses, Medication Administration Aide (MAA)s and Nursing Assistant (NA)s (including NA #1 & 3) will be re-educated to check kiosk for supportive devices on plan of care by DON/SDC/Supervisor by 9-7-16. Nurses, MAAs, and NAs not working those dates will be mailed an education packet to their home address on 9-7-16.	

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F 318	Continued From page 18 not explain why Resident #40 had not received restorative services as indicated on her plan of care for 17 out of 29 days. An interview was conducted with Restorative Nursing Assistant (RNA) #1 on 8/11/16 at 9:45 AM. She indicated she normally worked with Resident #40. She indicated she reviewed the documentation from the time period in question (7/13/16 - 8/10/16) for Resident #40. RNA #1 revealed that if restorative services were not documented that they had not occurred. She indicated if she had provided the restorative services to Resident #40 she would have completed the documentation. She stated she "just missed those days" . RNA #1 stated she received a computer generated list each morning of all residents she was assigned to provide restorative services. She indicated she had a large volume of residents on her caseload and sometimes she was not able to get to all of her residents. RNA #1 stated she had not been reporting to her supervisor, MDS Nurse #2, if she was unable to provide restorative services as indicated on her assignment sheet. A follow up interview was conducted with MDS Nurse #2, the supervisor restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services in March 2016. She indicated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had	F 318	Measures put in place to ensure deficient practice will not reoccur: System developed to have Assistant Director of Nursing (ADON)/RNA supervisor /MDS nurse audit restorative documentation at least 3 times per week and meet with RNAs to discuss any omissions or issues. Reports will be given to RNA supervisor for any omissions or issues and changes will be made to plans of care/orders as needed. Four new Restorative Nursing Assistants will be trained By Staff Development coordinator (SDC) by 8-31-16 and will be utilized to ensure services are provided as ordered. Caseload of RNA will be reviewed by DON/RNA Supervisor on an ongoing basis to ensure appropriateness of continued need for resident programs. A list of splints/ROM will be reviewed in weekly Trek meeting (a meeting to discuss: falls, weights, skin issues or any other incidents that is attended by (IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing). Any revisions given to the hall nurse/Supervisor by ADON for review in huddle meetings (a meeting for hall staff to discuss each resident's care or issues) with nursing assistants. Monitoring will be done by Charge Nurse/Supervisor/MDS Nurse on each hall 3 times per week for one year to ensure splints/supportive devices are in place as ordered/care planned for 10% or more of residents. This will be documented on a Splint/Supportive Devices Audit Tool,	

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F 318	Continued From page 19 also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments. A follow up interview was conducted with the DON on 8/11/16 at 10:30 AM. She indicated she expected restorative services to be provided as indicated in the plan of care. She stated she expected RNAs to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she had not known restorative services were not provided consistently. 2. Resident #4 was admitted to the facility on 10/12/12 with multiple diagnoses that included cerebral palsy. The significant change Minimum Data Set (MDS) assessment dated 6/23/16 indicated Resident #4 had significant cognitive impairment and a limited range of motion to one side of his upper extremities and both sides of his lower extremities. A review of Resident #4's plan of care, with a review date of 8/3/16, revealed interventions to address the prevention of further contractures to his bilateral lower extremities (BLE) and to maintain his current functional bed mobility. The interventions indicated restorative services were to provide a splint to Resident #4's bilateral knees 1 to 3 hours daily and assist with passive range of motion (PROM) to lower extremities and bed mobility exercises 6 days per week. A review of Resident #4's restorative services documentation from 8/4/16 through 8/10/16 revealedrestorative services were provided on 3	F 318	which includes Resident, device, in place – Y or N, if no what action was taken. Monitoring plan to ensure solutions are sustained: RNA Supervisor will report results of weekly audits on omissions quarterly to Quality Assurance Performance Improvement (QAPI) for one year as well as any changes made to the plan regarding documentation of splints/range of motion.	

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out of 7 calendar days. There were 4 days during the review period of 8/4/16 through 8/10/16 that Resident #4 was not provided restorative services. The 4 days that restorative services were not provided were: 8/4 and 8/6-8/8.

An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00 PM. She indicated she was the supervisor of restorative services. The restorative services documentation for Resident #4 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days.

An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40 AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days per week. She stated she reviewed the staff schedules for the dates restorative services were not provided to Resident #4 and confirmed that a restorative nursing assistant was working on each of those days. She revealed she could not explain why Resident #4 had not received restorative services as indicated on her plan of care for 4 out of 7 days.

An interview was conducted with Restorative Nursing Assistant (RNA) #2 on 8/11/16 at 9:45 AM. He indicated he normally worked with Resident #4. He indicated he reviewed the documentation from the time period in question (8/4/16 - 8/10/16) for Resident #4. RNA #2 stated that if restorative services were not documented that they had not occurred. He indicated if he had provided the restorative services to Resident #4 he would have completed the documentation. He stated he received a computer generated list

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each morning of all residents he was assigned to provide restorative services. RNA #2 indicated he had a large volume of residents on his caseload and on occasion he was pulled away from restorative services to assist the nurse on the floor. He stated that when he was pulled to the floor it was difficult to get back on track with his restorative services and to complete all of his assignments. RNA #2 stated he had not been reporting to his supervisor, MDS Nurse #2, if he was unable to provide restorative services as indicated on his assignment sheet.

A follow up interview was conducted with MDS Nurse #2, the supervisor restorative services, on 8/11/16 at 9:50 AM. She stated she began overseeing restorative services in March 2016. She indicated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments.

A follow up interview was conducted with the DON on 8/11/16 at 10:30 AM. She indicated she expected restorative services to be provided as indicated in the plan of care. She stated she expected RNAs to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she had not known restorative services were not provided consistently.

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3. Resident #107 was originally admitted to the facility 3/13/15. Cumulative diagnoses included dementia, hypertension, diabetes, dysphagia (difficulty swallowing), aphasia (absence of speech) and gastrostomy tube (feeding tube in the stomach).

A Significant Change Minimum Data Set (MDS) dated 6/14/16 indicated Resident #107 had short term and long term memory impairment and severely impaired in decision-making skills. Total care was required for all activities of daily living (ADL). Range of motion noted impairment on both sides for upper and lower extremities.

A care plan dated 8/4/16 indicated Resident #107 needed nursing ADL rehabilitation for her right upper extremity (RUE) related to possible contractures. Approaches included restorative nursing was to provide passive range of motion to RUE daily and apply splint to RUE daily for 3-4 hours. Use a calm, gently approach and monitor for skin breakdown.

On 8/10/16 at 8:05AM, an observation of Resident #107 revealed Resident #107 with a right elbow splint in place and a hand splint on her right hand.

On 8/10/16 at 10:51AM, an interview was conducted with NA#1. She stated restorative nursing had just started applying braces to Resident #107 ' s right elbow and hand last week. She stated the splints were applied by restorative staff, kept on for a couple of hours or so and removed by restorative nursing staff.

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A review of restorative nursing notes noted splint/ brace applied to Resident #107 ' s right elbow and hand on 8/4/16, 8/5/16, 8/8/16, 8/9/16 and 8/10/16. There was no documentation that the brace and splint had been applied to Resident #107 on 8/6/16 or 8/7/16.

An interview was conducted with MDS Nurse #2 on 8/10/16 at 3:00PM. She indicated she was the supervisor of restorative nursing services. The restorative documentation for Resident #107 was reviewed with MDS Nurse #2. She revealed she could not explain why Resident #107 had not received restorative as indicated on her care plan for 8/6/16 or 8/7/16.

An interview was conducted with the Director of Nursing (DON) on 8/11/16 at 9:40AM. The DON indicated the facility had a minimum of 1 restorative nursing assistant scheduled to work 7 days a week. She stated she reviewed the staff schedules for the dates restorative services were not provided for Resident #107 and confirmed a restorative aide was working on both days. She revealed she could not explain why Resident #107 had not received restorative services as indicated on her care plan.

On 8/11/16 at 9:47AM, an interview was conducted with Restorative Nursing Assistant #2. He stated he was responsible for the application of the brace and splint application for Resident #107 on 8/6/16 and 8/7/16. He stated restorative staff often got pulled to do other duties and it was hard to keep "on track" with restorative duties when that happened. Restorative Nursing Assistant #2 stated he was told to do other duties on 8/6/16 and 8/7/16 along with doing restorative nursing so he could not get to everybody. He

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F 318	Continued From page 24 stated if the brace and splint had been applied on 8/6/16 and 8/7/16, it would have been documented. A follow up interview was conducted with MDS Nurse #2, the supervisor of restorative services, on 8/11/16 at 9:50AM. She stated she began overseeing restorative services on March 2016. She stated she had not known that restorative services were not being provided consistently until it was brought to her attention yesterday. She stated she had just assumed the services were provided. MDS Nurse #2 indicated she was in the process of developing a system where restorative staff would need to sign off on their assignments at the end of each day to indicate if they had been completed. She stated she had also instructed restorative staff to inform her at the end of each day if they were unable to complete their assignments. On 8/11/2016 at 10:28AM, an interview was conducted with the Director of Nursing. She stated expected restorative nursing services to be provided as indicated in the plan of care. She stated she expected restorative nursing assistants to report to her or to their supervisor, MDS Nurse #2, if they were unable to complete their assignments. She indicated she had not known restorative services were not provided consistently.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		9/8/16

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F 323	Continued From page 25 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow the care plan for falls and failed to provide effective interventions to prevent further falls/accidents for 2 (Residents # 151 & # 13) of 3 sampled residents reviewed for accidents. Findings include: 1. Resident #151 was admitted to the facility on 8/18/15 with multiple diagnoses including Dementia. The annual Minimum Data Set (MDS) assessment dated 8/5/16 indicated that Resident #151 had severe cognitive impairment and had a fall with injury since admission, reentry or prior assessment. The assessment further indicated that Resident #151 needed limited assistance with transfer and toilet use. The assessment also indicated that the resident was continent of bladder and a trial of toileting program has not been attempted on admission /reentry. The care plan dated 8/8/16 was reviewed. One of the care plan problems was "I have falls related to history of recent fall" and the goal was "I will not have any injury related to falls." The approaches included chair alarm, bed in locked position, call light in reach, encourage resident to ask for assistance, gripper socks and night light in the bathroom. The fall risk assessments for Resident #151 were reviewed. The resident was assessed as medium risk for falls on 2/15/16 and 4/16/16 and a high risk for falls on 5/2/16 and 7/14/16. The incident/accident reports for Resident #151	F 323	F323 (D) Free of Accident Hazards/Supervision/Devices Trinity Glen will continue to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. For all residents affected: Resident #13 had pommel cushion and chair alarm placed on chair on 8-10-16. Resident #151 had chair alarm placed on chair on 8-10-16. Residents #13 & 151 were reviewed by the interdisciplinary team (IDT) (IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing) to assess the plan of care for accidents on 8-11-16. Resident #13 & 151 were discussed by team for toileting program. Bedside commode was placed in room of Resident #13 by Therapy on 8-11-16. Resident #13 sent to ED & expired on 8-13-16. Staff Development to educate staff on toileting plan for Resident #151 on 8-25-16 and then implement. For all residents that have the potential to be affected: All residents with a plan of care for falls	

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F 323	Continued From page 26 were reviewed. The report dated 4/16/16 at 4:48 PM indicated that Resident #151 had a fall trying to get in bed. The resident was instructed to use the call light and for safe transfer techniques. The immediate action taken was low bed which was already in place and bed and chair alarm. The report dated 5/2/16 at 8:00 AM indicated that Resident #151 was observed on the bathroom floor at 6:10 AM. The resident was instructed to use the call light and proper foot wear was provided. The report dated 6/5/16 at 11:43 PM indicated that Resident #151 was found in the bathroom with a laceration on her toe. The resident was instructed to use the call light and increase lighting in the bathroom. The report dated 7/14/16 at 12:00 AM indicated that Resident #151 was observed on the bathroom floor on 7/13/16 at 8:15 PM. The resident sustained an abrasion on her right elbow. The resident was instructed to use the call light and proper footwear was provided. On 8/10/16 at 10:45 AM, Resident #151 was observed up in wheelchair in her room. She did not have a chair alarm in her wheelchair. On 8/10/16 at 10:46 AM, NA #3 was interviewed. NA #3 was assigned to Resident #151. She stated that the resident was a high risk for falls and has a chair alarm to alert the staff that she was getting out of her chair. NA #3 added that she was off for 2 days and didn't know why the resident did not have the chair alarm in her wheelchair. NA #3 indicated that Resident #151 was continent of bowel and bladder, needed limited assistance with transfer and was independent with locomotion using a wheelchair. NA #3 also stated that Resident #151 was not on any toileting program.	F 323	were reviewed by the interdisciplinary team(IDT included: Therapy manager, ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator) on 8-25-16 for appropriateness of interventions to prevent further falls/accidents. Team made 14 changes to care plans and 38 order clarifications. Changes were made to the plans of care and orders were updated as needed on 8-25-16. Re-education will be done for the interdisciplinary team on specific interventions for falls/accidents (including bowel and bladder plans) by the Corporate Nurse Consultant on 9-1-16. Re-education will be done for nurses on interventions for falls/accidents and appropriateness to situation by Staff Development Coordinator (SDC)/Director of Nursing (DON)/Supervisor by 9-7-16. Nurses, Medication Administration Aide (MAA)s and Nursing Assistant (NA)s (including NA #2 & 3) will be re-educated to check kiosk for supportive devices on plan of care by DON/SDC/Supervisor by 9-7-16. Measures put in place to ensure deficient practice will not reoccur: All new interventions that are put into place following a fall will be reviewed in the weekly trek meetings (a meeting to discuss: falls, weights, skin issues or any other incidents that is attended by IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing) for effectiveness within one week of	

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F 323	Continued From page 27 On 8/10/16 at 11:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the care plan to prevent further falls. She added that Resident #151 should have a chair alarm when up in wheelchair. The DON stated that the incident/accident reports were reviewed weekly by the committee. She was aware that most of the resident's falls happened in the bathroom but had not tried a toileting program for the resident. The DON added that educating the resident to call for assistance was not effective due to her cognitive impairment. 2. Resident #13 was readmitted to the facility on 6/11/15 with multiple diagnoses including Alzheimer's Disease. The significant change in status MDS assessment dated 6/1/16 indicated that Resident #13 had severe cognitive impairment and had a fall with no injury. The assessment further indicated that the resident was always incontinent of bowel and bladder, needed extensive assist with transfer and toilet use and a trial of toileting program has not been attempted on admission /reentry. The care plan dated 7/3/16 was reviewed. One of the care plan problems was "I have a fall" and the goal was "I will have no injury due to falls." The approaches included chair alarm and pommel cushion in wheelchair. The fall risk assessments for Resident #13 were reviewed. The risk assessments dated 3/20/16, 4/17/16, 6/5/16, 7/13/16 and 8/6/16 indicated that Resident #13 was a high risk for falls. The incident/accident reports for Resident #13 were reviewed. The report dated 3/20/16 at 12:02 PM indicated that Resident #13 was	F 323	implementation and changes will be made at that time as needed. Any revisions will be given to the hall nurse/Supervisor by ADON each week for review in huddle meetings (a meeting for hall staff to discuss each resident's care or issues) with nurse, MAA, nursing assistants. Monitoring will be done by Charge Nurse/Supervisor/MDS Nurse on each hall 3 times per week for one year to ensure splints/supportive devices are in place as ordered/care planned for 10% or more of residents. This will be documented on a Splint/Supportive Devices Audit Tool, which includes Resident, device, in place – Y or N, if no what action was taken. Monitoring plan to ensure solutions are sustained: Facility Safety Director/Director of Nursing will audit 10 residents monthly for effective interventions and report findings to Quality Assurance Performance Improvement (QAPI) quarterly for one year. Plan will be monitored and changes made if needed.	

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observed on the bathroom floor at 11:35 AM. The immediate action was chair alarm. The report dated 4/17/16 at 3:26 PM indicated that Resident #13 was observed on the bathroom floor at 2:45 PM. The resident was noted to have a bruise on his lower back. The immediate action was low bed. The report dated 4/29/16 at 8:54 AM indicated that Resident #13 was observed on the floor in his room on 4/28/16 at 3:00 PM. The resident was educated on the use of call light. The report dated 7/12/16 at 4:00 AM indicated that the resident was observed on the floor at 1:50 AM. The resident was instructed on the use of call light and the immediate action was low bed. The report dated 8/6/16 at 5:55 PM indicated that Resident #13 was observed on the floor at 11:30 AM. The resident was instructed on the use of call light.

On 8/9/16 at 9:50 AM and on 8/10/16 at 11:30 AM, Resident #13 was observed up in wheelchair. Resident #13 was observed with no chair alarm nor pommel cushion in his wheelchair.

On 8/10/16 at 11:30 AM, NA #2 was interviewed. NA #2 was assigned to Resident #13. She stated that Resident #13 was a high risk for falls and has a chair alarm in his wheelchair to alert the staff that he was trying to get up. NA #2 added that the night shift staff got him up this morning and didn't know why he didn't have the chair alarm in his wheelchair. NA #2 also indicated that Resident #13 was not using a pommel cushion in his wheelchair.

On 8/10/16 at 11:35 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the staff to follow the care plan to

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F 323	Continued From page 29 prevent further falls. She added that Resident #13 should have a chair alarm and pommel cushion when up in wheelchair. The DON stated that the incident/accident reports were reviewed weekly by the committee. She was aware that some of the resident's falls happened in the bathroom but had not tried a toileting program for the resident. The DON added that educating the resident to call for assistance was not effective due to his cognitive impairment.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate at 5% or below by not administering the Lasix (diuretic) as ordered and not administering each medication separately via gastrostomy tube (GT). There were three errors of twenty five opportunities for error resulting in a 12 % error rate. Findings included: 1. Resident #46 was admitted to the facility on 11/16/15 with multiple diagnoses including Edema. The physician's orders for Resident #46 were reviewed. The orders included Lasix 40 milligrams (mgs) 1 tablet via GT three times a week on Monday, Wednesday and Friday. On 8/10/16 at 8:26 AM, Nurse #2 was observed during the medication pass. Nurse #2 was	F 332	F332 (D) Free of Medication Error Rates of 5% or More Trinity Glen will continue to ensure that it is free of medication error rates of five percent or greater. For all residents affected: Resident #46 & 107 had order to cocktail medications for Gastrostomy Tube (G-Tube) administration discontinued on 8-16-16 by Physician services. For all residents that have the potential to be affected: All residents with G-tubes had orders for medication administration via G-tube reviewed by physician services on 8-23-16, cocktail medication orders were all discontinued. All residents with	9/8/16

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F 332	Continued From page 30 observed to prepare the medications for Resident #46 except the Lasix 40 mgs 1 tablet. The nurse was observed to double check the medications and started to crush the tablets ready to be administered by GT. On 8/10/16 at 8:30 AM, Nurse #2 was interviewed. Nurse #2 acknowledged that she forgot to pull the Lasix tablet. Nurse #2 was observed to pull the Lasix and crushed it. On 8/11/16 at 10:33 AM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurse to administer the medications as ordered. 2. Resident #46 was admitted to the facility on 11/16/15 with multiple diagnoses including Edema and Seizure disorder. On 8/10/16 at 8:26 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare the medications for Resident #46 including Depakote capsule, Vimpat liquid, Ferrous Sulfate liquid, Plavix tablet, Potassium Chloride liquid, Dilantin tablet, B12 tablet, Metoprolol tablet and Omeprazole capsule. The nurse was observed to crush the tablets and then poured the liquid medications, crushed tablets and the contents from the capsule in one cup and dissolved them with water. The nurse was observed to flush the GT with water and then poured the dissolved medications and then flushed the tube with water. On 8/10/16 at 8:30 AM, Nurse #2 was interviewed. She stated that all the residents receiving medications by GT had a doctor's order	F 332	G-tubes had orders for medication administration via G-tube reviewed by Registered Dietician (RD) on 8-25-16 to assess for any possible outcomes of increased fluids and 3 order changes were made. Physician services & RD were educated on interpretive guidance to surveyors regarding administering medications via G-tube by Administrator on 8-25-16. All licensed Nurses (including nurse #1 & # 2) and MAAs will be educated on interpretive guidance to surveyors regarding administering medications via G-tube by Staff Development Coordinator (SDC)/Director of Nursing (DON)/Supervisor as they are scheduled by 9-7-16. Nurses and MAAs not working those dates will be mailed an education packet to their home address on 9-7-16. Measures put in place to ensure deficient practice will not reoccur: An Audit of orders and fluid restrictions will be monitored for residents with G- tubes by the Director of Nursing (DON)/Assistant DON each week to ensure medication orders do not state that they can be cocktailed. Director of Nursing/ADON/RN Supervisors/Pharmacy consultant will observe medication administration via G-tube seven days per week to include rotating all shifts and weekends for one week, then weekly for one quarter then monthly for remainder of one year to ensure procedures for medication administration were followed. Monitoring plan to ensure solutions are	

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F 332	Continued From page 31 to cocktail the medications. The nurse further indicated that Resident #46 was not on fluid restrictions. On 8/11/16 at 10:33 AM, The Director of Nursing (DON) was interviewed. The DON stated that she thought that medications can be administered together via GT as long as there was a doctor's order. She acknowledged that Resident #46 was not on fluid restriction. 3. Resident #107 was originally admitted to the facility 3/13/15. Cumulative diagnoses included dementia, hypertension, diabetes, dysphagia (difficulty swallowing), aphasia (absence of speech) and gastrostomy tube (feeding tube in the stomach). A Significant Change Minimum Data Set (MDS) dated 6/14/16 indicated Resident #107 had short term and long term memory impairment and was severely impaired in decision-making. A review of physician orders revealed, in part, the following medications: Metoprolol tartrate (for hypertension) 25 milligrams 1/2 tablet=12.5 milligrams enteral tube twice daily. Aspirin 325 mg via enteral tube daily, Atropine sulfate 1% solution (aids in decreasing secretions) 4 drops by mouth four times daily and Acetaminophen 160 milligrams/ 5 milliliter (20 milliliter/ 640 milligrams) enteral tube three times daily. Resident #107 did not have a physician's order for fluid restriction. On 8/10/16 at 7:50 AM, an observation of medication pass was conducted with Nurse #1 for Resident #107. She prepared the medications, crushed the medications together and administered them all at once. The medications	F 332	sustained: Director of Nursing/ADON/Pharmacy consultant will report findings regarding order audits, monitoring of medication administration via G-tube and any adverse effects to resident to Quality Assurance Performance Improvement (QAPI) committee. Plan will be monitored and changed if needed.	

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F 332	Continued From page 32 were not dissolved separately. On 8/10/16 at 8:00AM, Nurse #1 stated she gave the medications together because Resident #107 had a physician's order that stated may cocktail medications via G-tube (gastrostomy tube) flush with 50 cubic centimeters (cc) before and after medication administration. On 8/11/16 at 10:38 AM, an interview was conducted with the Director of Nursing. She stated she was unaware that medications administered via G-tube should be administered/ dissolved in water separately. She stated she thought if there was a physician's order to cocktail the medications, the facility would be covered. The Director of Nursing indicated Resident #107 was not on fluid restriction.	F 332		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		9/8/16

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F 431	Continued From page 33 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications in one of three medication rooms (100/200 hall) and failed to date the Budesonide (used to treat asthma) and Pulmicort (used to treat asthma) when opened and failed to discard expired medications in four of five medication carts (100, 300,400,& 500). The findings included: A facility policy titled " Short Dated Medications 2012 " stated, in part, " Humalog/ Novolog/Lantus/ Apidra (PENS) expires 28 days after pen is opened." The Levemir (long acting insulin) pen expired 42 days after pen was opened. A facility policy titled " Vials and Ampules of injectable Medications " dated 2/14/02 stated, in part, " 2. The date opened and the initials of the	F 431	F431 (E) Drug Records, Label/Store Drugs & Biologicals Trinity Glen will continue to label drugs and biologicals used in the facility in accordance with currently accepted professional principals, … and include the expiration date when applicable. For all residents affected: Expired medications including: (Bisacodyl suppositories, Lidocaine, Humalog flexpen, Budesonide, Pulmicort respules, Levemir, Novolog, and Lantus) were returned or wasted/discarded on 8-10-16 by Director of Nursing (DON)/Supervisor and replaced as needed. For all residents that have the potential to be affected: All med carts and med rooms were audited for expired medications and labels	

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F 431	Continued From page 34 first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose. " 1. On 8/10/16 at 2:30PM, an observation of the 300 hall medication room was conducted. There was four Bisacodyl suppositories (a suppository used for relief of constipation) with an expiration date of 4/2105 and six Bisacodyl suppositories with an expiration date of 7/2016. On 8/10/26 at 2:30PM, an interview was conducted with Nurse #1 who stated there was no one really assigned to check the medications and it was done by all nursing staff. She said the suppositories should have been discarded. 2. On 8/10/16 at 2:30PM, an observation of 300 hall medication cart revealed a 50 milliliter multidose vial of Lidocaine 2% 20 mg/ml (a local anesthetic agent) was opened and undated. On 8/10/26 at 2:30PM, an interview was conducted with Nurse #1 who stated there was no one really assigned to check the medications and it was done by all nursing staff. She said usually everything was dated when it was opened and the Lidocaine should have been dated when it was opened. 3. On 8/10/16 at 2:45PM, an observation of the 100/200 hall medication room revealed 46 Bisacodyl suppositories with an expiration date of 7/2016. On 8/10/16 at 2:45PM, an interview was conducted with Medication Aide (MA) #1. She stated it was the responsibility of all nurses to check for expired medications and no one was	F 431	by Unit Supervisors on 8-10-16. There were 3 expired and 2 unlabeled medications found and corrections were made immediately. Measures put in place to ensure deficient practice will not reoccur: Pharmacy will send yellow labels with all medications that are to be dated upon opening to remind staff to date medications on 8-19-16, which will be placed in each Med room and Med cart by SDC. Nurses and Medication Administration Aides (MAA) (including Nurse #1,3 & 4, MA 1 & 3) were re-educated by Staff Development Coordinator (SDC)/Director of Nursing (DON)/Supervisor about proper procedure for dating medications and expirations by 9-7-16. Nurses and MAAs not working those dates will be mailed an education packet to their home address on 9-7-16. SDC will add this information to orientation class. A system was put into place for nurses/MAAs to audit each cart 7 days per week (rotating all 3 shifts) for one quarter, one time per week (rotating all 3 shifts) for the remainder of one year, making any corrections and report to supervisors. Supervisors will audit carts and med rooms weekly for two quarters then monthly for the remainder of the year, and will review the reports from the nurses. Findings will be reported to DON. Monitoring plan to ensure solutions are sustained: DON/Assistant DON will report progress on expired medications/labels quarterly	

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F 431	Continued From page 35 specifically assigned to check for expired medications. She stated the Bisacodyl suppositories should have been discarded. 4. On 8/10/16 at 2:45PM, an observation of the 100 hall medication cart was conducted and revealed a Humalog flexpen opened and dated 6/30/16. On 8/10/16 at 2:45PM, MA#1 stated the Humalog flexpen should have been discarded 28 days after it was opened. On 8/10/16 at 3:45PM, an interview was conducted with the Director of Nursing. She stated she expected staff to discard expired meds and to date insulin and Lidocaine when opened. She stated every nurse was responsible to check the med carts and the nursing supervisor was responsible for checking the medication carts weekly and the medication room for expired meds weekly. 5. On 8/10/16 at 2:40 PM, the medication cart on 400 hall was observed. The box of Budesonide (used to treat asthma) was observed with two opened foil with four vials inside with no date of opening. The box of Pulmicort Respules (used to treat asthma) was also observed with one foil opened with two ampules inside with no date of opening. The manufacturer's instruction on the box of the Budesonide and Pulmicort read " once the foil envelope is opened, use the vial/ampule within two weeks. " On 8/10/16 at 3:10 PM, Medication Aide #2 (MA), assigned on 400 hall was interviewed. She stated that she did not know the policy or the manufacture's instruction for the Budesonide or the Pulmicort.	F 431	for one year to Quality Assurance Performance Improvement (QAPI) committee. If any trends arise, changes will be made to the plan as needed.	

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F 431	Continued From page 36 On 8/10/16 at 3:12 PM, Nurse #3 was interviewed. Nurse #3 stated that the Budesonide and the Pulmicort should be dated when the foil was opened. On 8/11/16 at 10:33 AM, The Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to follow the policy and the manufacturer's instruction in dating the medications after opening. 6. On 8/10/16 at 3:16 PM, the medication cart on 500 hall was observed. The following used/opened insulin pens were observed: Levemir - undated Novolog - open date on the sticker 5/11/16 and on the pen 6/25/16 Novolog - open date on the sticker 6/26/16 Lantus - open date on the sticker 6/3/16 On 8/10/16 at 3:25 PM, Nurse #4 was interviewed. Nurse #4 stated that she didn't check the cart because she was told that the cart had already been checked. The nurse added that it was the responsibility of the nurses to check the cart every day for expired medications. On 8/11/16 at 10:33 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the nurses to check their carts for expired medications every day.	F 431		
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.	F 520		9/8/16

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F 520	Continued From page 37 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. 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 maintain implemented procedures and monitor the interventions put into place following the 9/10/15 recertification survey. The facility had repeat deficiencies on accuracy of the Minimum Data Set (MDS) assessment and implementation of the care plan on the recertification survey 9/10/15 and the recertification survey 8/11/16. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included: These tags are cross referred to: F278 - Accuracy of the MDS assessments: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately for 4 (Residents #	F 520	F520 (D) QAA Committee Members/Meet Quarterly/Plans Trinity Glen will continue to maintain a QAA committee that meets quarterly to identify issues with respect to which QAA activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies. For all residents affected: Minimum Data Set (MDS) assessments were modified and transmitted by the MDS Nurse #1 for residents as follows: resident #13 (to reflect 2 falls no injury, 1 fall with injury) 8-10-16, #111 (to include dialysis)8-10-16, #59 (to include multiple falls with no injury and 1 fall with injury)8-10-16 & #28 (to include no hypnotic on quarterly 8-12-16 and no hypnotic on annual 8-24-16). Resident	

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F 520	Continued From page 38 13, #111, #59 & # 28) of 17 sampled residents in the areas of falls, dialysis and medication. During the recertification survey of 9/10/15, the facility was cited F278 for inaccurate coding for PASRR (Resident #86), medication (Resident #62) and pressure ulcer (Resident #101). F282 - Implementation of Care plan: Based on observation, record review, and staff interview, the facility failed to follow the plans of care for range of motion (Residents #40, #4, and #107) and accidents (Residents #13 & #151) for 5 of 17 sampled residents. During the recertification survey of 9/10/15, the facility was cited F282 for failure to implement the care plan for dialysis (Resident #62). On 8/11/16 at 10:45 AM, the Director of Nursing (DON) was interviewed for QAA. The DON indicated that she was the contact person for the QAA. She stated that the committee consisted of the Medical Director, Administrator, Director of Nursing and all the department heads. The committee had met quarterly. The DON indicated that she was aware that F278 and F282 were repeat deficiencies from the last year recertification survey. The inaccuracy of the MDS assessments was from the MDS Nurse #2 being new to her position and she was still learning MDS. The DON added that they were monitoring the provision of care as care planned but obviously not effective enough. Each resident had only one alarm to be used in bed and in the chair. The nursing aides forgot to transfer the alarm from the bed to the chair when getting residents up.	F 520	#13 had pommel cushion and chair alarm put into place on 8-10-16. Resident #151 had chair alarm put into place on 8-10-16. Residents #13 & 151 were reviewed by the interdisciplinary team (IDT included: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing) to assess the plan of care for accidents on 8-11-16. Resident #13 & 151 were discussed by team for toileting program. Bedside commode was placed in room of Resident #13 by Therapy on 8-11-16. Resident #13 sent to ED & expired on 8-13-16. Staff Development to educate staff on toileting plan for Resident #151 on 8-25-16 and then implement. Residents #40, 4, & 107 were re-evaluated by therapy to ensure treatment plans for splints/Range of Motion (ROM) were still appropriate on 8-24-16. Residents #40, 4, & 107 were reviewed by the interdisciplinary team including therapy to assess the plan of care for splints/range of motion on 8-24-16, plans were continued. For all residents that have the potential to be affected: Current assessments were reviewed by Registered Nurse (RN) consultant on 8-23-16 for other residents coded with falls, dialysis and hypnotic medications. No errors were noted on area of dialysis. 4 Corrections were needed in the area of falls. 9 corrections were needed in the area of hypnotic medications. Any errors identified were corrected through modifications and transmitted by MDS	

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F 520	Continued From page 39	F 520	nurse #1 on 8-24-16. All residents with orders for splints/ROM were reviewed on 8-24-16 by the interdisciplinary team (IDT) (IDT included: Therapy manager, ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator) to assess the continued plan of care. One splint/ROM order was added and one device order was discontinued as not an actual splint. All residents with a plan of care for accidents were reviewed on 8-25-16 by the interdisciplinary team (IDT included: ADON, Health Information, MDS Nurse #1, MDS Nurse #2, DON, Administrator, and Supervisor) to assess the continued plan of care. Team made 14 changes to care plans and 38 order clarifications. Changes were made to the plans of care for the most appropriate course of action and orders were adjusted to reflect changes on 8-25-16. Restorative Nursing Assistants (RNA) #1 & 2 were re-educated by Restorative Nursing Assistant (RNA) Supervisor on 8-11-16 and counselled by Director of Nursing (DON) on 8-26-16 regarding the omissions and the importance of range of motion and splinting. Four new Restorative Nursing Assistants will be trained by Staff Development Coordinator (SDC) by 8-31-16 and will be utilized to ensure services are provided as ordered. Nurses, Medication Administration Aides (MAA)s and Nursing Assistant(NA)s (including NA #1 & 3) will be re-educated by Staff Development Coordinator (SDC)/Supervisor/ Director of Nursing (DON) by 9-7-16 to check kiosk for supportive devices on plan of care.	

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F 520	Continued From page 40	F 520	Measures put in place to ensure deficient practice will not reoccur: MDS nurses #1 & 2 will be re-educated by 8-31-16 by the Corporate Nurse Consultant on accurate coding for MDS assessments including falls, dialysis and medications. An RN auditor (a registered Nurse that has MDS experience but does not have primary duty of MDS in this facility) will check any MDS' completed for residents with falls, dialysis, or hypnotic medications weekly for one quarter, then monthly for one year to verify that MDS has been coded properly. An audit tool will be used that lists: resident name; audit date; assessment date; MDS items listed in sections J (falls with or without injury or major injury), O (Dialysis), and N (antianxiety and hypnotic medications). Completed MDS will be verified by checking chart for resident in the areas of falls, dialysis and Medications; utilizing physician orders, MAR, nurses notes and incidents. Any modifications required will be made and transmitted at that time by MDS nurse. System developed to have Assistant DON/Staff Development Coordinator (SDC)/RNA Supervisor audit restorative documentation at least 3 times per week and meet with RNAs to discuss any omissions or issues. Reports will be given to RNA supervisor for any omissions or issues and changes will be made to plans of care/orders as needed. Caseload of RNA will be reviewed by DON/RNA Supervisor on an ongoing basis to ensure appropriateness of continued need for resident programs. A	

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F 520	Continued From page 41	F 520	list of splints and alarms will be reviewed in weekly Trek meeting (a meeting to discuss: falls, weights, skin issues or any other incidents that is attended by (IDT including: Administrator, MDS Nurse #1, MDS Nurse #2, Safety Director, Therapy Manager, Health Information, Dietary, Social Services, Activities, Nursing). Any revisions will be given to the hall nurse/Supervisor by ADON each week for review in huddle meetings (a meeting for hall staff to discuss each resident's care or issues) with nurse, MAA, nursing assistants. Monitoring will be done by Charge Nurse/Supervisor/MDS Nurse on each hall 3 times per week for one year to ensure splints/supportive devices are in place as ordered/care planned for 10% or more of residents. On 8-24-16, Administrator contacted Casey Conner, MHA, Quality Advisor for Alliant Quality, Quality Improvement Organization (QIO) of North Carolina to provide continuing education on Quality Assurance Performance Improvement (QAPI) process and refinements of maintaining implemented plans for effectiveness to the QAPI committee on 9-1-16. Monitoring plan to ensure solutions are sustained: Director of Nursing (DON)/Assistant DON will audit 5 completed MDS' monthly to ensure coding has been completed accurately and report to Quality Assurance Performance Improvement (QAPI) - (MDS Performance Improvement	

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F 520	Continued From page 42	F 520	Plan (PIP) team). The MDS PIP team includes MDS Nurse #1, MDS Nurse #2, DON, and Administrator. The team will identify any trends and change the plan as needed. MDS nurses will report the data collected and any changes made to the plan in the quarterly QAPI meeting for one year. RNA Supervisor will report results of weekly audits on omissions quarterly to Quality Assurance Performance Improvement (QAPI) for one year as well as any changes made to the plan regarding documentation of splints/range of motion and accidents. On 8-25-16, Administrator invited Casey Conner, MHA, Quality Advisor for Alliant Quality QIO of North Carolina to review the QAPI plans and progress of monitoring effectiveness once each quarter for one year to give an outside perspective to the QAPI process. Any changes will be made to plans as needed.	